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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

A TWO-DAY, STREAMLINED ANNUAL SESSION OF C.M.A. WILL BE HELD IN LOS ANGELES, MAY 2-3, 1943

Hotel Del Monte Becomes a Pre-Flight Naval School.—At the Council meeting held on September 13th, the Councilors tentatively agreed that it might be possible to hold a three day session (Monday, Tuesday, and Wednesday), at Hotel Del Monte, in accord with the action of the House of Delegates in May last; provided, complications did not arise.

However, such a complication came into the picture when, on December 5th, newspapers announced that, by the end of this year, Hotel Del Monte would be taken over by the U. S. Navy as a Pre-Flight School—an action confirmed by letter from the hotel management.

At a meeting of the C.M.A. Executive Committee, held on December 6th, this item was given place among the agenda. The Executive Committee recommended to the Council, in view of existing conditions, that next year's annual session be limited to two days, commencing on Sunday, May 2nd, and adjourning on Monday, May 3rd, 1943; and that headquarters should be at Hotel Biltmore in Los Angeles. This recommendation has since been approved by mail vote of the Council.

* * *

General Plan of the Two-Day Session.—Some brief comment on the general plan, in relation to meetings of the Scientific Assembly (General and Section Meetings) and the House of Delegates:

The first meeting of the House of Delegates will be called to convene at noon on Sunday, May 2nd, and the second meeting at 1:00 p.m., on Monday. This arrangement will permit the lapse of twenty-four hours between hours of *convening*, to conform to by-law provisions. (If the first meeting does not begin its work until 2:00 p.m., or so, the by-law provision will still have been observed.)

Two Scientific Meetings will be held, the first on Sunday, May 2nd, to begin probably at 9:00 a.m., and the second on Monday morning, commencing at the same hour.

The twelve Scientific Sections (General Medicine, General Surgery, Obstetrics and Gynecology, Eye-Ear-Nose and Throat, Anesthesiology, Dermatology and Syphilology, Industrial Medicine

and Surgery, Neuropsychiatry, Pathology and Bacteriology, Pediatrics, Radiology, and Urology) will hold meetings on Sunday, May 2nd, commencing at 1:30 p.m. During this period it will be possible for each Section to present four or five papers, and elect officers for the succeeding year. Several of the larger sections may wish to also hold meetings on Monday afternoon. This program will permit the official journal, CALIFORNIA AND WESTERN MEDICINE, to come into possession of a supply of up-to-date papers on topics of pertinent medical interest and value.

The established custom, of a Dinner to the President, will probably be followed, the banquet, open also to wives and guests, to be held on Sunday evening.

Affiliated Societies, which in the last several years have been meeting at Del Monte on the Sunday immediately preceding the annual session, will be obliged, owing to lack of meeting room accommodations, to hold their sessions on Saturday, May 1st, or Monday afternoon, the third, or Tuesday, May 4th.

* * *

C.M.A. Headquarters will be Hotel Biltmore.—The headquarters of the session will be the down-town Hotel Biltmore at Fifth and Olive, opposite Pershing Park. This hotel is not far distant from the depot, and may be conveniently reached through streetcar accommodations, if taxi service is not available. Its meeting-room facilities are comparatively good; and in the near vicinity are many parking lots. Concerning such items, full information will be given in due course of time.

* * *

Nature and Scope of Scientific Programs.—Wartime medicine, with emphasis upon the three phases which have so sharply differentiated themselves during the last year (military, essential industry, and civilian) will receive emphasis. Advances in medical science, as brought out in these aspects, and general and specialty medicine likewise will receive attention. Also, careful consideration will be given to other features, such as medical and surgical films, and scientific and various exhibits. There will be no display of commercial or technical exhibits in 1943.

* * *

Registration May Be Large.—The arrangements, as outlined, will permit the California Medical Association to carry on its work without interruption, avoiding lapse of an annual session—but with due consideration of the stress and strain of present-day practice. It follows that the attendance from county societies throughout the State will not be as great as in recent years, but with the large membership of Los Angeles County (2825 members), it is possible that, after all, the registration, at least on Sunday, May 2nd, may be very large.

The hope is expressed, therefore, that members throughout the State, who can arrange their work, will make an earnest effort to be present at this two-day, streamlined annual session of year, 1943.

THE STATEWIDE MEDICAL SERVICE—CALIFORNIA PHYSICIANS' SERVICE—TAKES OVER GOVERNMENTAL CONTRACTS (RURAL HEALTH AND WAR HOUSING PROJECTS)

Some Past History.—California physicians who have maintained interest in the efforts of Organized Medicine to solve some of the economic and other problems connected with the task of making available an adequate medical service to citizens who belong to lower income groups, are somewhat familiar with the trials and tribulations encountered by the California Medical Association, in placing the state-wide medical service—California Physicians' Service—on a sound financial basis.

The decision to form such an organization under the sponsorship of a constituent state medical association came only after proposed plans had been a subject of serious consideration and discussion at regular and special meetings of the House of Delegates of the California Medical Association; those efforts having commenced in very active form at the Riverside Annual Session in year 1934.

When finally launched on its course, the new nonprofit organization for medical service glided into the waters on a plan that incorporated full coverage service—although the infant organization had only a very limited capital in dollars and cents, and an underwriting group in the form of California physicians who were willing to give professional services on a unit basis—a set-up which experience proved to be too idealistic, to be actuarilly or, rather, financially sound for a medical service program, so extensive in scope.

* * *

Contract Changes Brought about through Experience.—In due course, at the end of one, two and three years of operation, it was found necessary to trim the contracts, through procedures that would cut out avoidable and consequent over-head and expense.

Members of the medical profession need not be reminded that the hardships of unforeseen and unpredictable illness and injury are related, not to minor, transient conditions, but rather to major diseases and injuries that require extensive medical or surgical care and hospitalization. It is in these latter cases that illness and injuries can result in catastrophe to individual and family savings and happiness.

Accordingly, in due time, as announced by California Physicians' Service, plans were put into operation whereby full-coverage contracts should be discontinued, until perhaps some future day when sufficient reserves will warrant. Within the next six months, all full-coverage contracts still existing will have been completed.

Today deductible contracts (contracts in which the first two visits for an illness must be personally paid by the patient), and limited surgical contracts (for specified surgical procedures), are the only forms that are being sold to eligible groups on the prepayment basis.

* * *

A Creditable Career.—California Physicians' Service, as regards attainment of all its initial objectives, has not been entirely successful. However, in the face of great obstacles, C.P.S. has made real progress, and with the continued good will and coöperation of the physicians of California, should be able to demonstrate that Organized Medicine can carry through, to success, a state-wide medical plan; and also, at the same time, compensate its underwriters — the professional members — with unit payments of fair value. When these two achievements are realized, the large mass-spread of beneficiary members will then permit the accumulation of adequate reserves, to provide also for epidemic or other unforeseen expenses.

To recall the progress of C.P.S.: In September, 1939, it had 1,220 beneficiary members; in December, 1940, 20,993 members; in December, 1941, 32,562 members; and at the present time, it has 37,871 beneficiary members.

It should be kept in mind, however, that the decision to discontinue the sale of full-coverage contracts, necessarily resulted in loss of a considerable number of members, with resultant retardation of increase in unit values to professional members.

It was unfortunate that some of the conditions which came into being during the last three years of operation created confusion, and added to sales management difficulties, so that a number of desirable coverages, involving possible acquisition of some thousands of beneficiary members, could not be consummated. However, those experiences are as water that has gone over the dam. The reassuring element lies in the fact that, in spite of the storms which C.P.S. was forced to weather, it has come through and is maintaining itself on a self-supporting basis, and that there is assurance, when the coverage changes now being carried out are completed, it will be possible to compensate physicians who have enrolled as professional members, with stipends that will approximate the income that would have been received from the same group of patients; namely, from the beneficiary members of California Physicians' Service, had they continued as individual patients in regular private practice.

* * *

More Recent Activities of C.P.S.: Provision of Medical Service in Federal Rural Health and Housing Projects.—C.M.A. members who are in the habit of reading the information presented in the California Physicians' Service department which appears in each issue of CALIFORNIA AND WESTERN MEDICINE, may have noticed the comments concerning the trial experiments that were being carried on by C.P.S. in coöperation with Federal agencies, concerning medical service to be given in connection with Rural Health and Housing projects.*

Perusal of the items referred to will reveal to readers who are interested the picture as it exists in its present form.

It is most gratifying that the Federal Authorities who are charged with the supervision of these important governmental projects have given evidence of their faith in the capacity of California Physicians' Service to provide an adequate medical service to two important groups of citizens, through the contracts that have been made in regard to agricultural workers coming under the Farm Security Administration, and to workers in essential war industries who are living in structures erected by the Federal Public Housing Authority.

* * *

Important Announcement in Current Issue.—To bring these comments to close, members are urged to read, in CALIFORNIA AND WESTERN MEDICINE's current issue, the details concerning some of the activities now under way.† It should be heartening to members of the California Medical Association that C.P.S., the state-wide, non-profit organization for medical service they have sponsored, has been able to perform some of its functions with such beneficent end-results for certain population groups in California, who were in need of adequate medical care.

Special appreciation, therefore, is expressed by the officers of the California Medical Association to the large number of professional members whose loyal service and generous coöperation have made it possible for California Physicians' Service to carry on its work. Many of these professional members, on numerous occasions, in order to coöperate with the announced purposes of the California Medical Association, were obliged to accept financial compensation—on the unit basis—in much lesser amounts than the totals that would have been given to them by some beneficiary members who had previously been their private patients. That, by and large, the professional services were so well rendered, redounds to the credit of the individual physicians and to the medical profession as a whole. So once again, to them, and to all who have given aid, in professional service and in advice, thanks are expressed.

From now on, gradually, but increasingly brighter, the sun should shed a warmer glow on California Physicians' Service.

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* For informative items in relation thereto, see issues of CALIFORNIA AND WESTERN MEDICINE: May, page 323; June, page 371; July, page 106; August, page 159; October, page 264; November, page 326; and in this current December issue, on page 380.

† See page 379.

SENATOR PEPPER HEARINGS ON PROCUREMENT AND ASSIGNMENT SERVICE

Hearing Transcript Appeared in "Journal A.M.A."—Commencing on November 2, 1942, Senator Claude Pepper of Florida, acting largely as a one-man representative of a subcommittee of the U. S. Senate Committee on Education and Labor, conducted in Washington, D. C., a rather extensive hearing, the transcript of which appeared in the November 21st issue of the *Journal of the American Medical Association.* In small type, the report of the proceedings covered some 42 pages!

Reference is made thereto because it is a question whether many physicians who receive the *Journal A.M.A.* took the time to read the lengthy testimony, a considerable portion of which deals with statements bearing on California; more particularly the "Permanente Foundation Hospital" established in the remodeled Fabiola Hospital of Oakland, and designed for medical and hospitalization service for workers in the Richmond Shipyards operated by the Henry J. Kaiser interests—the organization given credit for building cargo ships of considerable tonnage in 5 days or so, although competent authorities have stated that the man-hours used on all parts of the ship amount to calendar days of work that perhaps approximate from 30 to 60 days or more!

* * *

Hearing Received Much Newspaper Comment.—Much publicity appeared in the newspapers during the progress of the hearing. In the *Journal of the American Medical Association,* the "Pepper Hearing" received editorial comment, the issue of November 21st presenting a transcript of the testimony, from which excerpts appear in this current issue of CALIFORNIA AND WESTERN MEDICINE.* Members of the California Medical Association should be interested in reading the queries and statements made by the California physician, Sidney R. Garfield, M. D., with headquarters in Oakland, who is chief of a staff of some thirty physicians working out of the "Permanente Foundation Hospital." (News items concerning dedication of the institution appeared in CALIFORNIA AND WESTERN MEDICINE, September, page 221, and November, page 334.)

The excerpts from the testimony given by Morris Fishbein, M. D., editor of the *Journal A.M.A.,* in answer to queries put by the Senator from Florida—who, throughout the hearing, gave repeated evidence of his state of mind in relation to the National Procurement and Assignment Service, and also to the American Medical Association—furnish illuminating reading.

It is hoped that all C.M.A. members who have not yet done so will mark the items for perusal. No further comment will be made here concerning the testimony, because it speaks for itself, both in what is printed and what is evident between the lines.

* See page 360.

Permanente Hospital of Oakland: Some Excerpts from its Literature.—However, in regard to the "Permanente Foundation Hospital"* in Oakland, it may not be out of place to print, for the information of C.M.A. members, two items worthy of thought, especially when considered in relation to what has been stated above concerning the Pepper Hearings (or "Pepper Inquisition," as it was styled by Editor Fishbein).

From page 2 of an eight page illustrated brochure that was distributed to shipyard employees, through foremen and other representatives, the following quotation:

"A HEALTH PLAN
For the Employees of
the Richmond Shipyards

"This is a Health Plan.* Its primary purpose is *to prevent illness* through medical treatment and hospitalization for nonoccupational illnesses and accidents. To this end, First Aid stations are located in all of the yards. A Field Hospital is located at Richmond, and, for the more serious cases, services are available at the Permanente Foundation Hospital, Broadway and MacArthur Boulevard, Oakland, California.

"The medical and hospital services which you will receive under this Plan are provided by Sidney R. Garfield, M. D., who will maintain a Staff composed of more than thirty physicians and surgeons. The Staff will include specialists in the major divisions of medicine, so that each subscriber will be furnished with the attention of a specialist whenever recommended by the attending physician."

* * *

From a footnote, also on page 2, the following illuminating item:

*"This outline is a digest of the hospital and medical services which are provided under the agreement between the three Richmond Shipyards and Sidney R. Garfield, M. D., whereby Dr. Garfield has agreed to furnish medical and hospital services to the eligible employees of the shipyards who have subscribed to such services. The shipyards have agreed to make weekly deductions for the employees who have subscribed and on behalf of such employees *to pay the amount deducted to Dr. Garfield.* Copies of the agreement itself are on file and available for inspection by any employee at the Personnel Office in each yard." (Note. Italics by Editor.)

* * *

In connection with the footnote quoted above, the "Health Plan Application" for employees, which follows, should also take on additional significance.

(COPY)

HEALTH PLAN APPLICATION

Yard No..... Badge No.....

Name .....
Last First Middle

I HEREBY APPLY for participation in the Health Plan for Employees of the Richmond Shipyards, Richmond, California, and hereby voluntarily authorize my employer to deduct fifty cents each week from wages hereafter earned by me, and on my behalf to pay said

* Information has been received from the Secretary of State of California that his office has no record of a corporation of the name "Permanente Foundation."

amount for medical and hospital services as provided in the agreement providing for such services, a copy of which is on file with my employer, and a digest of which I have received.

.....
Signature
Date....., 1942

NOTE: This Plan is now available in Yards 1 and 3. Employees of these Yards may sign up immediately. The Plan will be available in Yard 2 as soon as appropriate arrangements can be made.

* * *

Would it not be in order, taking into consideration the above, for us to ask ourselves the question, What do these statements in the brochure mean, and what will be the total amount of money turned over to Sidney R. Garfield, M. D., under the above arrangements in this supposedly nonprofit plan sponsored by the Kaiser interests?

Perhaps Doctor Garfield will be willing to furnish this and related information. If so, it may clarify some phases of the "Health Plan" activities that seem a bit obscure.

EDITORIAL COMMENT†

NEWER TERMINOLOGY FOR SERUM "COMPLEMENT"

The new terminology for serum complement currently suggested by Pillemer and Ecker[1] of the Institute of Pathology, Western Reserve University, may well pave the way for new or improved methods of diagnosis and treatment of infectious diseases.

Originally conceived as a single protective enzyme, the serum component known as "alexin," or "complement," was separated into two components by Ferrata.[2] On treatment with distilled water, fresh guinea pig serum was separated into a globulin and an albumin fraction, neither of which is capable of activating "amboceptor." If the albumin and globulin fractions are reunited, however, the original activating power is restored. It was found that the same separation into two inactive components can be effected by saturating the serum with CO_2,[3] or by slight acidulation.[4] It was afterwards shown by Whitehead,[5] of Leeds University, that the globulin and albumin fractions thus prepared are almost invariably impure, one or both of them containing an adsorbed "third factor" essential for complement action. This "third component" is readily removed from guinea pig serum by adsorption on yeast or on zymin (insoluble residue left after repeated extraction of yeast with alcohol, ether and distilled water). The relatively pure albumin ("end-piece") and globulin ("mid-piece") are not affected by such adsorption. The "third component" is thermostable so can be obtained free from the thermolabile proteins. Added to an inactive purified albumin-globulin mixture the "third component" restores the original complement titer.

Somewhat later, a fourth essential factor was discovered in hemolytic complement, usually existing as an adsorbed contaminant on serum albumin ("end-piece"). Gordon[6] and his colleagues found that guinea pig serum could be inactivated by the addition of a small amount of ammonia (0.25 cc. n/6.5 NH_4OH per 1 cc.) without demonstrable injury to the end-piece (albumin), mid-piece (globulin) or "third component." The fourth factor thus destroyed is nondialysable and relatively thermostable. It is not identical with the previously discovered "third component," since it is not adsorbed on yeast or zymin.

Hemolytic complement (C), therefore, is not a unit enzyme as postulated by earlier serologists, but a functional metaphor or immunologic abstraction, symbolizing the complex interaction of four semi-independent normal serum fractions: "mid-piece" (globulin) + "end-piece" (albumin) + "third component" + "fourth component." "Complement fixation" also becomes an archaic metaphor now mainly of historic interest.

Pillemer[7] and his colleagues have recently added to these well-established complexities by further fractionation of these components. Electrophoretic diagrams prepared in the Department of Physical Chemistry, Harvard Medical School, for example, indicate that mid-piece and end-piece each consist of a mixture of at least four distinct serum proteins. Whether or not all eight proteins are essential for full complement action has not yet been determined. The terms "mid-piece," "end-piece," "albumin fraction" and "globulin fraction" thus also become archaic and in the opinion of Pillemer should be discarded in favor of his non-committal terminology: C'_1, C'_2, C'_3 and C'_4. The discovery of races of guinea pigs hereditarily deficient in C'_3[8] and the apparent correlation of one or more of these factors with vitamin C,[9] are perhaps prophetic of future clinical applications of his terminology.

P. O. Box 51.

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Stanford University.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

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ORIGINAL ARTICLES

Scientific and General

ABORTION: INEVITABLE AND INCOMPLETE*

A STUDY OF 500 CASES

JAMES W. RAVENSCROFT, M. D.
San Diego

A DISCUSSION of this subject is appropriate for these reasons:

1. Abortions are common.
2. Women die from abortions.
3. Treatment is controversial.

Abortions are not rare. They occur rather frequently in the practice of every general practitioner, as well as in that of the obstetrician, and our hospitals are seldom without them.

Dr. Taussig[1] has stated that 20 per cent to 25 per cent of pregnancies terminate in abortion. It is the greatest single factor in maternal and fetal mortality, and approximately 40 per cent of maternal deaths are due to abortion.

This presentation deals with the clinical management of incomplete and inevitable abortions. The charts of 500 consecutive cases in the San Diego County Hospital from January, 1937 to June, 1941, have been personally analyzed in an attempt to ascertain the results and the important factors of treatment. Complete abortions, therapeutic abortions, and missed abortions have been excluded from this study.

DIAGNOSIS

Correct treatment first necessitates correct diagnosis. The vast majority of these cases consulted medical care because of one or more of the following reasons:

1. Vaginal bleeding, usually associated with passage of clots.
2. Lower abdominal pain, often of crampy nature.
3. Passage of decidual tissue or a fetus.
4. Evidence of infection, such as general malaise, foul lochia, tenderness of abdomen, or chills and fever.

The above signs and symptoms, associated with a history of amenorrhea in a woman in the childbearing age, usually make the diagnosis evident. However, as these signs and symptoms are also associated with a myriad of other disturbances of the female pelvis, it is not surprising that missed diagnoses do occur. Virginia Hamilton,[2] in 1941, reported 13 per cent missed diagnoses on admission in a series of 502 cases of abortion. It is not within the scope of this paper to discuss differential diagnoses, but I do want to call to your attention that, occasionally, cases of pelvic inflammatory disease, hydatidiform mole, ectopic pregnancies, uterine polyps, ovarian cysts, fibroids, and malignancy of the cervix and corpus, masquerade as incomplete abortions. In the first 8 or 10 weeks of pregnancy the differential diagnosis is sometimes especially difficult, and it often requires a diagnostic curettage, with study of microscopic sections, to ascertain the correct diagnosis.

HISTORY

Granted a correct diagnosis, one is especially interested in ascertaining if instrumentation has occurred. This study shows that 90 cases, or 18 per cent of the patients admitted criminal interference. Some 70 per cent of such criminal abortions ran an infected course, while only 30 per cent of noncriminal cases were infected. This is important, because it is infection that accounts for most maternal mortalities in abortion. The history of previous criminal abortion is important. The author was impressed with the fact that too many women habitually have criminal abortions, until they almost die from severe infection. Also, many women deny criminal interference on admission, to confess it later in the hospital stay. It is also important to learn how many times the uterus has been invaded, as cases of repeated invasion run a more stormy course. The date of invasion is significant. If evidence of clinical infection does not manifest itself within one week, it is not likely to so do. The history of previous gonorrhea and pelvic inflammatory disease should be noted. If such history of recent infection is obtainable, the author believes that a course of sulfanilamide or sulfathiazole is justifiable before curettage, if such operative procedure is needed. Criminal abortion by medical means only does not increase the incidence of infection. The history of chills and fever classify the case as septic.

GENERAL EXAMINATION

The general appearance of the patient, the pulse rate, temperature, blood pressure, presence of jaundice, and evidence of tenderness, spasticity, or rigidity in the abdomen are very significant.

PELVIC EXAMINATION

The author has seen written on the admission record of charts, "Infected abortion; pelvic examinations deferred." Some physicians have advised that, in such cases, pelvic examination should not be done, because of the danger of spreading the infection. However, it seems to me that such procedure, done under sterile conditions, with good light and, above all, with gentleness, is invaluable, and often beneficial. Tenderness on motion of the cervix means parametritis, and that the infection has already spread beyond the limit of the uterus. This is an aid in prognosis, because it is this type of case that is most dangerous, causes the highest mortality

* Read before the Section on Obstetrics and Gynecology, at the Seventy-first Annual Session, of the California Medical Association, Del Monte, May 3-6, 1942.

rate, and which should not be curetted until infection is under control. In addition, most cases bleed freely, or go on to hemorrhage, due to decidual tissue in the cervix or lower uterine segment. In such cases the amount of bleeding can be appreciably decreased by removal of such tissue, often without anesthesia, by ovum or sponge forceps, even in the presence of infection. In most cases, such loosened decidual tissue blocks drainage from the cervix and favors the increase of infection. It is at times possible to complete abortion by this method of sponge forceps removal, or at least to establish good drainage. In 71 cases of the 500, such a procedure was done with good results. However, repeated pelvic examinations by several members of a hospital staff are to be condemned. Pelvic examination should not be abused.

LABORATORY AIDS

The presence of leucocytoses, with a shift to the left of polys, is indicative of infection. However, the white blood count is only an aid in diagnosis, and a normal count certainly should not be construed as meaning no infection. Each of the two patients in this study which died, and each of which was severely infected on admission, had respective white blood counts of only 8,050, with 73 per cent polys, and 11,700 with 86 per cent polys. The red blood count and hemoglobin determination, taken on admission, generally give a good idea of the degree of blood loss. Blood-typing should be done on all cases which may need transfusion. Neither sedimentation rates, nor cervical cultures were taken in these cases.

PERIOD OF OBSERVATION

Almost everyone agrees that active bleeding or hemorrhage demands evacuation of the contents of the uterus, even in the presence of infection. Forty-eight cases, or roughly 10 per cent in this series, had surgery within the first 24 hours after hospitalization, because of bleeding. As previously stated, most cases bleed because of decidual tissue in the cervix or uterus, which can often be removed with sponge forceps, sometimes without anesthesia. This procedure is less likely to spread infection than curettage, in infected cases. The author agrees that it is generally better to observe the patient 48 hours before surgery, if bleeding is not excessive, for the following reasons:

1. Infection may manifest itself during this time, which was not evident before.
2. A few patients will admit criminal abortion who denied it on admission.
3. Some cases will completely abort, especially cases of inevitable abortion on admission, and surgery will not be needed.
4. The period of absolute bed rest, high fluid intake, etc., improves most patients.
5. Patients who are in need of blood can be transfused.
6. The cervix in many patients further dilates, softens, and effaces, so that subsequent removal of the products of conception is easier.

At the end of 48 hours' observation, the attendant should be able to decide whether or not the abortion is complete; and he should also be able to decide an even more important factor, namely, whether or not the case is infected, and, if so, the degree of spread of the said infection.

TREATMENT

As stated previously, what constitutes proper treatment is controversial. I have just returned from the American Congress of Obstetrics and Gynecology, held in St. Louis, where I heard two interesting discussions of the proper treatment.

Dr. T. K. Brown, of St. Louis, who has written considerably on the subject, advocated active treatment; that is, intervention of the uterus in every patient, whether clean or infected, regardless of the degree of spread of said infection.

He[3] empties the uterine cavity of débris under morphine-scopolamin semimarcoses, by a Foerster's sponge forceps and with, what he terms, a uterine wiper. He then gives a low pressure, 1-1000 KMNO4 douche, at 110 to 115 degrees Fahrenheit.

Dr. James Reinberger, of Memphis, Tennessee, exemplified the other extreme; namely, medical treatment, and claimed that 97 per cent of his cases were cured by oxytoxics, blood transfusion, and sulfonimides. It[4] was necessary to curette in only 3 per cent of his cases.

I feel that Dr. Brown's régime is too radical; such intervention is sometimes dangerous. We simply have been unable to empty the uterus in 97 per cent of cases, as Dr. Reinberger did, by use of medical treatment alone. However, the author believes in a "middle-of-the-road" course between these two types of treatment, and recommends a procedure as follows:

After 48 hours' observation, in noninfected, incomplete abortion, the evacuation of the uterus by dull curettage or sponge forceps. This removes decidual tissue and blood clots, which offer a fertile culture media for growth of bacteria. After the uterus is emptied, it contracts well, diminishing blood loss and aiding drainage.

In infected cases he advises a more conservative course. Any tissue blocking drainage should be removed from the cervix. The patient should be kept at absolute bed rest, given an adequate amount of fluids, and oxytoxics, such as small doses of pituitrin and ergonovine. Blood transfusions should be given, if needed, either to restore blood loss, or to increase resistance. Sulfanilamide or sulfathiazole is invaluable. The uterus can be emptied with either sponge forceps or by dull curettage, after the patient is fever-free for 3 to 4 days. The following charts show the method of treatment, with the number of hospital days, of the cases in this series. Thirty per cent were treated medically, 26 per cent treated with

sponge forceps; curettage was done in 44 per cent of the cases.

An analysis of cases is presented in Tables 1, 2, and 3.

TABLE 1.—*Incidence of Infection and Criminal Interference*

	Criminal	Noncriminal	Total
Infected	64	113	177
Noninfected	26	297	323

TABLE 2.—*Method of Treatment of Cases*

	Infected	Noninfected	Total
Medical	64	87	151 cases (30%)
Sponge Forceps	50	82	132 cases (26%)
Curette	63	154	217 cases (44%)
Total	177	323	500 cases (100%)

TABLE 3.—*Hospital Days in Relation to Method of Treatment*

	Infected	Noninfected
Medical	8.4 days	6 days
Sponge Forceps	9.8 days	6.6 days
Curette	8.1 days	5.9 days

In 15 cases receiving conservative care only, the patient had to return for subsequent curettage; and in 3 cases the patient returned for curettage, after sponge forceps only. In 6 cases a second curettage was needed.

FLARE-UP AFTER SURGICAL TREATMENT

Every patient who received either sponge forceps or curettage, and who had a fever of 101 degrees following surgery, excluding the day of surgery, was restudied. In 25 cases, or 7 per cent of surgically-treated patients, such a flare-up occurred. Nine of these cases had sponge forceps, and 16 had curettage. However, only 5 of the 25 cases having postoperative reaction had had sulfonimides before surgery. All of these patients recovered. Half of the cases which flared up were subjected to surgery in less than 24 hours after admission. However, it should be noted that it is not unusual for such flare-ups of fever to occur immediately after spontaneous passage of placental tissue or fetus. In such cases the temperature usually subsides within 2 to 3 days.

BLOOD TRANSFUSIONS

Blood transfusions were used in 112 cases, and some patients were transfused as many as 5 times. Whole blood is very valuable, as it not only restores blood loss, but increases the resistance of the patient to overcome her infection.

SULFONIMIDES

Either sulfathiazole or sulfanilamide was used in 118 of the 177 infected cases. The author believes that the administration of these drugs is invaluable in such infected cases. Cases receiving such treatment should, of course, have a re-check white blood count to determine developing leucopenia. The drugs should be stopped upon the appearance of severe toxic manifestations. Occasionally their administration causes a fever which confuses the attendant. Of the two patients, which died, one received sulfanilamide for only 3 days, starting on the 5th hospital day; and the other received a total of 15 injections of Prontosil. Both these patients were extremely septic, and the drugs did not influence the patients' down-hill course.

REPORT OF CASES

CASE 1.—E. K., a white married female, age 28, Para. 11 Gr. IV, complained of general malaise, nausea, and vomiting, and vaginal bleeding 24 hours prior to admission. She passed clots, but no known tissue prior to admission. Denied criminal abortion. On admission, the uterus was enlarged, boggy and tender, and there were parametritis, spasticity of the lower abdomen, and jaundice. Laboratory Work: Icterus index 22; red blood count 1,720,000; hemoglobin 35 per cent; white blood count 11,700; with 86 per cent polys. The patient passed a small piece of tissue on admission, which showed inflammatory exudate, and necrotic tissue which could not be identified. The patient ran a temperature of 99 degrees to 101 degrees, and in spite of four blood transfusions, developed progressive weakness, vomiting, abdominal distention, foul lochia, and cyanosis. Sulfanilamide was administered for 3 days prior to death, which occurred on the 8th hospital day.

* * *

CASE 2.—L. R., a 21-year-old married woman, para. 0, Gr. 1, pregnant 4 months. Criminal abortion by abortionist. Had fever of 104 degrees, chills, rigid abdomen, and sepsis prior to admission. History of gonorrhea, with removal of right tubo-ovarian mass, a few months previously. Patient had sponge forceps removal of products of conception on 2nd hospital day. This was done without anesthesia, and cervix was widely dilated. About 5 gm. of placental tissue, removed, showed necrosis. Red blood count 3,874,000; hemoglobin 64 per cent; white blood count 8,050, with 73 per cent polys. Three blood cultures positive for staphylococcus aureus. Patient ran a temperature of 103 to 105 degrees, and had chills in the hospital. Death occurred, on the 9th hospital day, of peritonitis, sepsis and bronchopneumonia. Prontosil was given from the 3rd to 6th hospital days, a total of 75 c.c., without benefit.

CONCLUSIONS

1. Five hundred cases of incomplete or inevitable abortions were studied.
2. Ninety cases, or 18 per cent, admitted criminal interference.
3. Seventy per cent of criminal cases ran an infected course, while only 30 per cent of noncriminal cases were infected.
4. Two patients, severely infected on admission, died—a mortality of 0.4 per cent.
5. The author advises:
   a. A complete history and examination on admission, including a sterile pelvic examination.
   b. Speculum examination and removal of loosened decidual tissue from the cervix on admission, to establish surgical drainage, and to decrease blood loss.
   c. A 48-hour observation period, unless bleeding demands intervention.
   d. Early evacuation of noninfected, incomplete cases, with sponge forceps or dull curette.

e. Conservative treatment with oxytoxics of infected incomplete cases until the temperature is normal for 3 to 4 days, before surgical intervention.
f. Generous use of blood transfusions.
g. Administration of sulfanilamide or sulfathiazole to infected cases, especially before surgical intervention.

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FOREIGN BODY LOCALIZATION BY X-RAY*

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THE purpose of this paper is to review methods of foreign-body localization by x-ray that can be used by the civilian radiologist in his own office or hospital on standard equipment. It is necessary that civilian radiologists become familiar with at least one simple rapid fluoroscopic method by which foreign bodies can be localized, because we all are going to be confronted with the necessity of helping the surgeon find and remove these bodies from civilians if a continental bombing should occur; or from evacuees from the Far Eastern scene, when they are returned for base hospital care.

If there is no hurry, films taken at right angles through a part, shown to contain a foreign body by fluoroscopic survey, is still an excellent method of localization. One not only demonstrates the type, number, and shape of the foreign particles, but one has a record of their position relative to anatomical structures, and a record of other injuries such as fractures.

However, if the number of patients is great, there will not be time for this method. Fluoroscopic localization will have to be relied upon. It is the only method acceptable to the army in emergency stations.

Time does not permit even a hasty review of the many papers written on this subject. Reid and Black, in *Radiology*, in November, 1938, listed and discussed 147 papers on foreign-body localization and added a new method. Since that time several other methods have been described. Major de Lorimer, in *Radiology*, April, 1941, described the method used by the Army. For those interested, these papers are recommended for survey.

* Read beore the Section on Radiology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.
From the University of California Hospital.

PROCEDURES

For your own office, however, you will find some difficulty in applying the described methods, unless you are willing to change the design of your machine. But several things can be done to help this situation.

The requirements are that the number, type, shape and position of foreign bodies be stated concisely. The position is usually given as the depth of a particle beneath a mark on the skin directly over the foreign body, or a mark is placed on the skin over the foreign body and its depth marked on the side of the patient.

Subcutaneous foreign bodies can be localized rather simply if one will make a metal-tipped exploring rod and determine the movability of foreign bodies by pressure on the skin over them. If such are found, their position should then be marked, and they should be labeled as subcutaneous.

For *localization of deep foreign bodies*, parallax can be used. To demonstrate the method, make a V (for victory) of the index and middle fingers of your left hand. Hold the hand about a foot from your face, so you look through the V. Put the tip of your right index finger half-way between your eye and the top of the V. Now, move your head from side to side. The index finger seems to move relative to the V. Now put the tip of your right index finger directly between the tips of the V, and move your head from side to side. Now the three fingers do not move relative to each other. The metal-tipped rod can be used beside the patient at the level of the foreign body as a parallax indicator. The screen and tube are moved back and forth. When the foreign body and the rod tip move the same amount, regardless of the tube shift, they are at the same level. In practice, a mark is placed on the skin over the image of the foreign body as seen through a very small shutter-opening, and a mark is placed on the side of the patient at the position of the rod tip. (See page 226, Army Manual.) There are special devices described, using the parallax principle. Some have rather elaborate, but simply-used scales to help determine the position of the foreign body in centimeters or inches from the front and back surfaces of the body, as well as marking its depth on the side of the patient. See Fig. 1.

DESCRIPTION OF APPARATUS

To simplify the explanation of the following methods, we will name a few parts of the apparatus. See Fig. 2. The rod connecting the tube carriage with the upright to the fluoroscopic screen is called the tube-carriage rod. A hand operated screw clamp which, when tightened, holds the tube and screen immovable relative to the table, is called the tube clamp.

A short, thick-walled tube, drilled to fit the tube carriage rod, and tapped to admit a small wing screw to tighten it to the rod, is called a rod-marker. This rod-marker is very handy. It need not be used in any of the methods, but it makes all of them easier to work. One can use a wax pencil to mark the position of the tube carriage rod relative to the rod clamp for marking the position of the tube relative to the table.

The Army uses a double tube shift triangulation method. Major de Lorimer's article gives a concise and graphic description of the method. However, it probably cannot be used as described on your own standard machine, because a focal screen distance of 66 centimeters is required. A method using this principle can be applied, however, if your tube and screen move together, if your screen is parallel to the table top, if you can determine the distance from your screen to the skin, and if there is a fixed target-screen distance or an easily-reproducible target-screen distance.

Most standard fluoroscopic tables allow about a 7-inch crossways shift of the tube and screen, and operate conveniently at a 24-inch target-screen distance. Choose a distance of crossways shift of the tube which is near the maximum and an even number of inches. For instance, if the tube will shift 7 inches, choose 6 inches as a working distance. Adjust the position of the screen so that the target-screen distance is 4 times the chosen crosswise shift. (In the above case, that would be $6 \times 4 = 24$ inches.) Fit a piece of cleared film to the frame of the fluoroscopic screen. Put a cross at the center of the image when the screen is lighted through a very small shutter opening. Put a cross on the right and left sides of the center cross at equal distances from it, so that the distance between the outside crosses is equal to the chosen crosswise shift of the tube. (In the above case, one would put a cross 3 inches on either side of the center cross.)

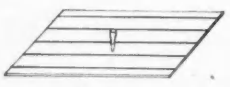

FIG. 102. Ruled celluloid sheet to indicate equality of displacement of two shadows in *Method B*.

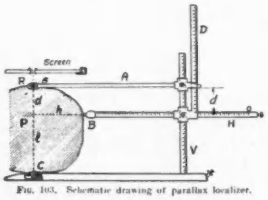

FIG. 103. Schematic drawing of parallax localizer.

Fig. 1.—(From U. S. Army Manual.) When B and P move the same amount while the screen is shifted from side to side, the two are at the same level. From this sort of a scale one can read *d* and *h* directly.

Locate the foreign body by fluoroscopic survey with the patient in the anatomical position. Close the shutter to a small opening and put a mark on the skin directly over the image of a point on the foreign body, as seen through this very small shutter opening.

Make the image of the foreign body coincide with the right hand cross. Mark the tube carriage rod at the place where it comes out from the side of the table with a pencil. Make the image of the foreign body coincide with the left-hand cross, and again mark the tube carriage rod as before. Measure the distance between the two marks. (Suppose this is 4¾ inches.) The difference between this measurement and the distance between the outside crosses (i.e., $6 - 4\frac{3}{4} = 1\frac{1}{4}$) is one-fourth of the distance from the screen to the foreign body, (i.e., $1\frac{1}{4} \times 4 = 5$ inches from screen to foreign body.) Subtract the screen-skin distance. This gives the depth of the foreign body beneath the mark on the skin.

Fig. 2.—Foreign-body localizer used at the University of California. This is a view of the apparatus, with the fluoroscopic table top removed.
W is the wire. C is the tube clamp. T is the tube-carriage rod. R is the rod-marker.

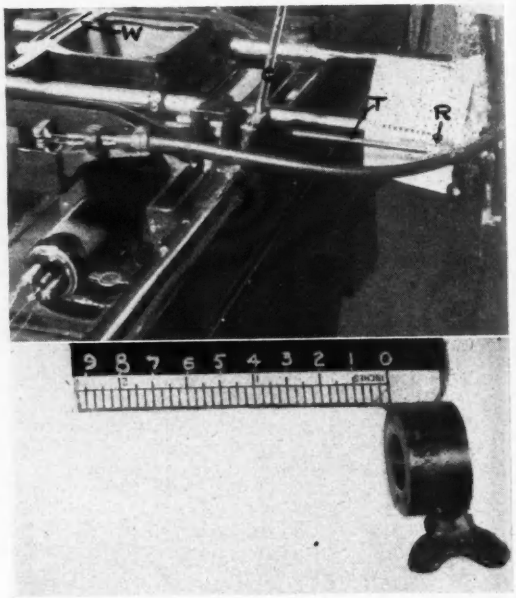

Fig. 3.—The detail picture below shows a close-up of the rod-marker.

You will find that marking the skin over the foreign body, and determining the screen-skin distance are difficult unless special apparatus is used.

DEPTH OF FOREIGN BODY

The next method allows one to read the depth of the foreign body on a scale on the fluoroscopic screen. It can be done in complete darkness, but the scale is so small (8 to 1) that large errors are possible.

Set the screen so that the tube-screen distance is 24 inches. Put a piece of cleared film over the screen, so that it will just fit the frame of the screen. Light the fluoroscopic screen through a very small shutter-opening. Put a cross on the

cleared film at the exact center of the lighted portion of the screen. To the left of this put a cross exactly 3 inches from the center cross. On the line of the centers of the crosses, and to the left of them mark off ⅛ inch intervals, and number them consecutively from 0 at the left cross. Each ⅛ inch represents 1 inch.

Locate the foreign body by fluoroscopic survey and move the screen so that the image of the foreign body coincides with the center cross. Mark the skin over the foreign body. Move the tube to the right exactly 3 inches. The image of the foreign body falls on the scale, giving its distance from the screen directly in inches. Subtract the screen-skin distance.

The simplest way to move the tube exactly 3 inches is to cut a piece of tongue-blade exactly 3 inches long. After the foreign body is centered to the center cross, fasten the rod marker tight against the tube clamp. Move the tube over until the 3-inch piece of tongue blade fits snugly between the rod marker and the tube clamp. Clamp the tube. Read the depth of the foreign body on the scale.

PROCEDURE AT U. C. HOSPITAL

The system used at the University of California obviates the necessity of having a fixed target-screen distance, and of determining the skin-screen distance. It does necessitate taping an opaque marker on the skin over the image of the foreign body.

Place a lead number (0) on the table top. Pile wood or magazines on top of it to a height of exactly 8 inches. Place another number (7) on top of the magazines and adjust its position so that the point of the 7 lies directly over the center of the 0 as seen fluoroscopically through a small shutter-opening. The screen must be parallel to the table top at any distance above it. On the tube carriage above the shutters place a straight, stiff wire near the edge of widest possible beam (a wire taped to a tongue blade works well). Move the tube and screen sideways until the image of the wire cuts through the center of the 0. Mark the position of the tube carriage rod relative to the side of the table. Now move the screen more sidewise in the same direction until the image of the wire passes through the point of the 7. Mark this position of the tube carriage rod relative to the side of the table. This will turn out to be nearly 2 inches. Now readjust the position of the wire until the distance between the two marks on the tube rail is exactly 2 inches when the above described maneuver is carried out. Once this position is found, fix the wire in this position. This should require not more than 2 or 3 minutes. The magazines and lead numbers are then removed and never need be used again. See Fig. 2 and Fig. 3.

To localize a foreign body in the tissues, find its image on the screen, and take a BB shot or any other small opaque marker directly over it on the skin. Move the screen sidewise until the image of the foreign body and the wire coincide. Mark the tube carriage rail at the side of the table, or move the rod-marker against the tube clamp. Move the screen until the image of the wire coincides with the image of the skin marker. Mark the tube carriage rail at the side of the table or tighten the tube clamp. Measure the distance between the two marks or between the rod-marker and tube clamp and multiply by 4. This gives the distance between the skin marker and the foreign body. Actually a small 4-to-1 scale may be attached to the rod-marker as is shown in the figure. This system has the advantage that skin-screen distance does not need enter the calculations, and that the screen can be close to the table top for thin parts and far away for thick parts. The wire and the rod-marker do not interfere with regular fluoroscopy.

SUMMARY

The principles of the parallax double-tube shift and a parallelogram method of foreign body localization by x-ray are described.

Simple ways of applying these methods to the civilian radiologists' machines are outlined.

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CARCINOMA OF THE FALLOPIAN TUBE*

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MALIGNANT tumors of certain organs of major surgical importance are so overshadowed by the much greater frequency of inflammatory disease in these sites that a diagnosis of the malignancy in an early local stage is practically never made preoperatively. Further, the enlargement and adherence produced by the two disease processes are so similar that the presence of a tumor is often not suspected even during the removal of the organ, and the discovery is left for the pathologist's routine examination.

Carcinoma of the Fallopian tube presents an outstanding example of this problem. It is rare in comparison with chronic salpingitis, and, when it does occur, it often resembles closely the inflammatory disease.

The most recent compilation[3] gives the upper limit of incidence of this lesion in gynecological operations as 0.5 per cent, and the total number of reported cases as about 375. Additional recent reports[2, 4, 5, 6] have added a few to this number. One author estimates the frequency as one in 1,000 salpingectomies.[5]

Age, in half the patients, is between 40 and 50, with the remainder between 18 and 80. The typical pathological description[1] is that of a club-

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From the Kimball Clinical Laboratory, and the Department of Pathology of the College of Medical Evangelists.

shaped adherent tube resembling an old pyosalpinx. The tumor is usually papillary and arises in the lateral half, sealing the fimbriated end but leaving the uterine ostium open. Fluid of inflammatory or degenerative origin distends the lumen, and escapes at intervals into the uterine cavity, giving rise to the phenomenon of "Hydrops tubae profluens." This is characterized by a profuse watery or blood-stained ("Hemohydrops") vaginal discharge, which follows and appears to relieve pain in the region of the tube. This symptom, correlated with negative findings on uterine curettement, is said to enable a correct preoperative diagnosis to be made, or at least suggested—a feat which has been accomplished only once or twice in all the reported cases. The prognosis is poor, not only because of lack of recognition and consequent nonradical removal of the tumor, but because of the thin-walled structure of the tube, ready access to lymphatics, and a tendency to occur bilaterally. Five-year cure is said to be obtained in less than 4 per cent. The value of roentgen irradiation has not been proven. Of the following case reports, the first two are from the Physicians' and Surgeons' Hospital of Glendale, and the third from the Glendale Sanitarium and Hospital.

REPORT OF CASES

CASE 1.—A white woman, age 49, was first seen May 11, 1936. She complained of severe abdominal cramps and excessive vaginal bleeding. She had had one pregnancy, with a normal delivery. For 16 years she had noted dull pain in the lower abdomen, and menorrhagia. Examination revealed good nutrition, apparent anemia; and in the lower abdomen, an irregular hard tumor extending to the umbilicus. Vaginal examination indicated this to be a uterus enlarged by multiple fibroid tumors. The hemoglobin was 50 per cent (Sahli), red-blood cell count 4.1 million. Other findings were normal.

Fig. 1.—Case 3. Left Fallopian tube. Posterior view. Lateral portion cut open to show the papillary tumor in the lumen. Enlarged 1½ times.

On May 12, 1936, laparotomy (H.E.S.) disclosed a large fibromyomatous uterus. One Fallopian tube was moderately enlarged and thickened throughout. The other tube and both ovaries appeared normal. The uterus was removed supracervically with the tubes. The patient recovered from the operation uneventfully.

Pathology. (T.S.K.) The uterus shows nothing of significance except the large multiple fibromyomata. One of the tubes is 7 cm. long, 2 cm. in diameter. Half of this tube is very firm in consistency, and the lumen is filled with firm white tissue grossly appearing to be tumor. The other half of the tube is filled with gelatinous fluid. The other tube shows some distention of the lumen and flattening of the mucosal folds, but no evidence of tumor.

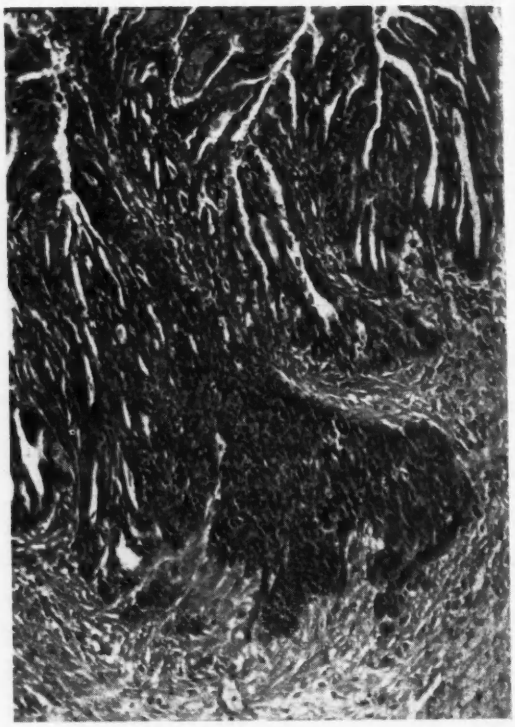

Fig. 2.—Case 3. Carcinoma of Fallopian tube. x475, showing the deep invasive margin of the tumor. In this area there is marked anaplasia, with loss of gland structure.

Microscopic. Sections of the Fallopian tube show an infiltrating growth of irregular glandular epithelium having a marked tendency to be thrown into folds, suggesting the probability that the tumor is primary in the tube itself.

Diagnosis. (1) Multiple fibromyomata of the uterus; (2) Fibroid polyp of the uterus; (3) Adenocarcinoma of the Fallopian tube.

Further course. Upon dismissal from the hospital the patient was advised to submit to radiation therapy, but she refused, and was not heard from again until Nov. 11, 1937. She was then found to have apparent cervical lymph node metastasis, and ascites. Laparotomy, necessitated by apparent intestinal obstruction, revealed peritoneal carcinomatosis, and the patient died Dec. 25, 1937, 19 months after the original operation.

* * *

CASE 2.—A white woman, age 54, had complained recently of abdominal pain, and a feeling of pressure in the pelvic region, made worse by standing. Examination

was negative, except for a mass palpable in the right lower quadrant. The hemoglobin was 79 per cent (Sahli), red-blood cell count 4 million.

Operation by Dr. H. G. Westphal, Dec. 11, 1936, revealed a large mass involving the right tube and ovary. Some excess abdominal fluid was noted. Both tubes and ovaries were removed, also the appendix.

Pathology. (T.S.K.) Specimen consists of a small tube and ovary, an appendix, and a large cystic mass having the gross appearance of a greatly dilated Fallopian tube with a large cyst of the ovary. The proximal end of the tube is of small diameter, but the remaining portion measures from 3 to 5 cm. in diameter, and has a rough, irregular external appearance. Sections through the tube at various places show the lumen to be almost completely filled with a papillary type of tumor which extends from near the proximal end for a distance of 9 cm. along the tube, at which point the lumen becomes larger and filled with a large mass of necrotic material which grossly resembles fibrin and decolorized blood clot. There is no evidence of tumor growth within this large cystic cavity, and the tumor is definitely limited to the Fallopian tube. The other tube reveals no evidence of tumor growth.

Microscopic. Sections of the Fallopian tube, at two different levels, show the lumen to be almost completely filled with a rather highly malignant-appearing tumor, having a distinct papillary arrangement suggesting the tube as the primary source. Many mitotic figures are present, and there is a poor attempt at gland formation.

Diagnosis. Carcinoma of the Fallopian tube, tubo-ovarian cyst, incidental appendix.

Further course. Dr. Westphal reported that the patient developed ascites and an apparent pelvic carcinomatosis. She died about a year and a half after the operation.

CASE 3.—The patient, a white woman of 37, consulted a physician in 1939, because of vaginal discharge. This consisted of a clear pink fluid which appeared during the three days preceding each period. There was considerable pelvic discomfort during this time. After each period there was also a discharge of brown fluid, lasting several days. The past history included a partial oöphorectomy incidental to appendectomy in 1919; and an abortion, the only pregnancy, in 1925.

The discharge ceased, after curettement and symptoms were relieved, until February, 1941, when an apparent acute attack of pelvic inflammatory disease occurred. This subsided under medical treatment, but symptoms, such as backache and dysmenorrhea, remained. The periods of dysmenorrhea were followed by serous drainage from the vagina.

Operation for chronic pelvic inflammatory disease was done December, 1941, by Dr. B. P. Mundall. The left tube was enlarged in its lateral portion, resembling an old pyosalpinx, and adherent to the sigmoid colon and left ovary. The left ovary appeared otherwise normal. The right tube was moderately thickened and adherent, and the right ovary contained small cysts. Supracervical hysterectomy, bilateral salpingectomy, and partial resection of the right ovary were done.

Recovery from the operation was uneventful.

Pathology. The material, from the curettement in 1939, showed a small benign endometrial polyp and fragments of normal follicular endometrium.

The specimens from the recent operation show a normal-sized uterus with slightly hyperplastic but smooth and thin-layered endometrium. The tubes show moderate chronic salpingitis. In addition, the lateral third of the left tube is enlarged to a diameter of 2.5 cm., and the dilated lumen in this portion is filled with a friable papillary growth. This does not involve the outer surface. The lateral ostium is partially sealed and was probably completely closed before separation of the adhesions. The medial portion of the tube is patent. No evidence of tumor is found, grossly, or microscopically, elsewhere in the specimens. The fragment from the right ovary shows chronic inflammatory change only.

Microscopic. Sections of the tubal growth show an epithelial tumor invading the wall rather shallowly and projecting into the lumen as a papillary mass. The deeper portions of the tumor are partially alveolar and partially solid in structure. The cells are fairly uniform, but large and dark-staining, with moderately numerous mitotic figures. Groups of the tumor cells are found in the lumen of a small vessel near the outer edge of the wall.

Diagnosis. (1) Uterus without lesion; (2) Papillary adenocarcinoma of Fallopian tube; (3) Chronic oöphoritis.

COMMENT

The histories of these patients illustrate the difficulty of diagnosis, both before and during surgery. In the first case the clinical picture was dominated by the large uterine fibromyomata; in the second case, the tumor apparently failed to produce a tubo-uterine discharge; and in the third case the pain and discharge cycle, though present, was not entirely typical. In all three instances, the changes observed in the tubes at the time of surgery were not distinguishable from those of chronic inflammatory disease.

Two of the patients succumbed in less than two years after the discovery of the malignancy. The postoperative period in the third case has been too brief to allow any conclusions, but the tumor seemed grossly much less extensive than in the other cases. This patient may, therefore, be expected to survive considerably longer, though hope of a complete cure is somewhat depressed by the microscopic evidence of intravascular growth of the tumor cells.†

A study of these and other reported cases suggests that the prognosis might often have been somewhat improved by an immediate opening of all significantly enlarged tubes and inspection of the contents. Recognition of the tumor could then be followed by appropriately radical excision.

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† The patient has now had a second operation, ten months later, revealing a recurrence of the tumor in the pelvis.

CONTACT STOMATITIS DUE TO A DENTURE IN A METAL SENSITIVE PATIENT

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A CASE of contact stomatitis in a metal sensipatient (nickel-cobalt), was found to be due to the nickel content of a denture made of a dental casting alloy, "Ticonium." Contact stomatitis, due to dentures consisting of synthetic material (hecolite), has been described by Rattner.[1] The following studies and observations appear to be of interest.

REPORT OF CASE

The patient is a married, white woman, forty-three years old. Her general history is irrelevant. No allergic manifestations such as pollinosis, asthma or eczema had been observed among any of her relatives. She stated that, approximately three years ago, she had acquired an upper partial dental plate, but she had been unable to wear it because it caused the following disturbances in her mouth:

A few hours after it was put in place, the patient noticed slightly increased salivation; and after approximately twelve hours, a burning and itching sensation. If the denture was removed, after twelve to fourteen hours, these disturbances would disappear in a few hours, except for a slight redness in the area of contact of the denture and the mucosa.

If the denture was left in the mouth for approximately twenty-four hours, the mucosa became inflamed and finally ulcerated, leaving a denuded area approximately two millimeters in depth, with elevated edges. An inflammatory edema involved the whole mouth, particularly the soft palate. The itching and burning increased, until it became practically unbearable. If the denture was not replaced, the lesion disappeared gradually and completely.

The plate was recast to insure a better fit, as it was assumed that the lesions were due to pressure against an unusually sensitive mucosa. However, the patient was unable to tolerate the new denture.

COMMENT

At this time, one of us (Dr. G. Rutledge Sheets), covered the denture with Eugenol paste and instructed the patient to wear the plate. The patient was able to wear the plate without symptoms for a period of time, in which symptoms had always developed on previous trial. A part of the Eugenol was removed, the metal exposed, and a lesion developed in the mouth exactly corresponding to the area of contact. Contact stomatitis due to the denture was assumed.

After the problem was discussed with the patient, she produced, at a subsequent visit, three items, namely, a ring, part of a wrist watch and a necklace. She stated that she had worn the ring for several months when she developed, on the area of contact of the ring and her fingers, an itching skin lesion which returned every time she again wore the ring for two or three days.

The alloy, of which the denture was made, proved to be Ticonium, the constituents of which are (according to the manufacturer), nickel, cobalt, chromium, molybdenum and beryllium.

FURTHER TESTS

Nickel sensitivity was suspected, and the following patch tests were carried out: The denture itself, a strip of Ticonium, a strip of dental gold and a buffalo nickel were cleaned with acetic acid, and applied to the skin of the upper arm so that they remained in close contact.

After forty-eight hours, typically positive patch tests had developed under the denture, the strip of Ticonium and the buffalo nickel. The skin under the strip of dental gold showed no change. After twelve hours the itching had become very marked.

On two successive occasions these tests were repeated in combination with nickel sulfate solution, 5 per cent. On each successive trial the patch test reactions occurred and were comparatively more severe. The nickel solution elicited a typical positive patch test.

Contact with a small piece of nickel produced a characteristic lesion on the patient's palate after ten hours.

Passive transfer tests with the patient's serum, in which the sensitized areas were patch tested with nickel, gave negative results.

A nickel-free casting material was found in the commercial product, "Vitalium." A preliminary patch test gave, to our surprise, a positive reaction. According to the manufacturer, Vitalium consists of cobalt, 65 per cent; chromium, 30 per cent, and molybdenum, 5 per cent.

Patch tests with the following solutions gave these reactions: chromium potassium sulphate 10 per cent aqueous, negative; cobalt chloride 2 per cent aqueous, positive; molybdenum, not done.

CONCLUSION

It was concluded: 1—that the patient was nickel- and cobalt-sensitive; 2—that her oral lesions represented a contact stomatitis.

The etiology and pathology of this contact stomatitis were thought to be the same as that of her skin lesions, which were of the nature of a contact dermatitis in a nickel-sensitive patient.

The alloy used for her denture was a widely used, commercially available alloy: Ticonium.

DISCUSSION

The initial sensitization was thought to be due to the nickel-containing ring. It was worn at first without symptoms for at least two months. During that period a local and general sensitivity to nickel developed. Contact with nickel in the same ring, in a wrist watch and a necklace produced skin lesions, and the time of these occurrences (after ten hours of contact), suggests that at that time the sensitivity had been well established. ("Beschleunigte Reaktion.")

Extensive exposure to nickel during patch-testing further intensified and sped up the reaction of the patient.

Nickel-containing alloys are frequently used in dentistry as casting alloys for dentures. They remain in prolonged and intimate contact with

body tissues under conditions which favor their solution in liquid media and their absorption.

It is to be expected that patients already sensitized to nickel, or those who become sensitized while wearing their dentures, will develop a contact stomatitis. Among cases of nickel sensitivity nickel contact dermatitis is a comparatively frequent form of clinical nickel sensitivity. It is not infrequently seen in patients whose history gives no suggestion of heavy or prolonged exposure, and it is to be assumed that these patients become exceptionally readily sensitized due to some undetermined predisposing factor.

It is suggested that nickel sensitivity be suspected in patients who wear metal dentures, and who develop local or general stomatitis, if no other explanation can be found for their stomatitis.

A careful history and the simple procedure of patch-testing the patient with the material to be used in the denture will reveal an already existing nickel sensitivity, and save the patient and the dentist much inconvenience. However, a previously normal patient may become sensitized while wearing the dentures, and in such a case patch-testing may or may not be helpful, depending on whether or not the sensitization has become generalized.

The medico-legal aspect is to be remembered, as the patient might claim negligence on the part of the dentist. The dentist certainly would not want to be less careful regarding his methods than the operator in a beauty salon, in which a patch test is an established routine before an application of a skin-sensitizing hair dye.

Finally, attention is called to the possibility of metal sensitivity or metal sensitization, its potentially grave sequelae and the necessity for patch testing, in the use of alloys in orthopedic surgery, where such alloys remain in prolonged and close contact with human tissue when they are used in bone surgery, as plate screws, nails and lag screws. Attention should be paid to metal sensitivities in complications after the use of alloys in bone surgery, and it is suggested that the irritating qualities of such alloys may be due, in an occasional case, to sensitivity to one or more of the metallic constituents.

SUMMARY

A case of contact stomatitis due to nickel sensitivity in a metal (nickel, cobalt), sensitive patient is described. The significance of metal sensitivity in dentistry and orthopedic surgery is discussed.

357 Thirtieth Street
426 Seventeenth Street

REFERENCE

1. Rattner, Herbert: "Stomatitis due to Sensitization to Dental Plates," Journal American Medical Association, 106:2230, 1936.

Germs were first seen by man in 1676 when Anthony Leeuwenhoek made a one-lens microscope.

Loss of only 20 per cent of the body's water content causes death.

TOXEMIAS OF LATE PREGNANCY: OUTLINES OF THERAPY*

ERNEST W. PAGE, M. D.
Berkeley

THE presentation of a system of therapy for the hypertensive disorders of pregnancy in tabular and outline form has an advantage in its simplicity and readiness for use. The summary below has been prepared primarily for the physician who is only occasionally confronted with such toxemias, and who has not the time for studying the innumerable articles on the subject. Much of the current literature bearing on the treatment of toxemias is concerned with specific aspects of treatment, often based upon some favored theory as to etiology; or it discusses the treatment of eclampsia in such general terms, with so many alternate methods of therapy, that practical directions are difficult to obtain. An outline such as this, on the other hand, is quite inadequate for the specialist who is interested primarily in the academic arguments relating to therapy. Many of the reasons for accepting or rejecting a procedure or a drug, and the references pertaining thereto, are sacrifices to brevity.

Until the exact etiology of the hypertensive syndromes is known, the treatment must remain symptomatic. We have learned much about the pathologic physiology of eclampsia, and this information is our only basis for any rational therapy. The methods outlined below have been modified gradually over a period of years, and are derived from many sources. They are quite identical with those now in use at both the Alameda County Hospital and the Los Angeles County Hospital.

CLASSIFICATION AND INCIDENCE

Hypertension, as a symptom, appears in three to ten per cent of pregnancies, the actual incidence depending upon the type of sample selected for study. The classification of that hypertension is important to the patient only insofar as it determines the prognosis and treatment. Several classifications have been devised, and four of these are presented in Table 1.

It will be noted that, in all classifications, there are two major divisions: the "pure" or specific toxemia peculiar to pregnancy and the various preëxistent vascular or renal diseases complicated by pregnancy. Occasionally there are mixed types, the former being superimposed upon the latter; but this should not deter us from attempting an exact diagnosis. The frequency distribution of the different groups is also shown in the table, and in the last column these percentages have been determined for both a hospital and a private series. The hospital cases show a much higher incidence of hypertensive complications simply

* Read before Section on Obstetrics and Gynecology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

because those patients were referred in for treatment, but the types of cases observed are otherwise similar.

There is very strong evidence that arteriolar and glomerular damage may persist after preeclampsia or eclampsia, especially when the toxemia was of long duration. When these women become pregnant again they may, in late pregnancy, present a syndrome quite like that of essential hypertension, though differing in several details. This syndrome I have labeled "post-eclampsism toxemias." The remaining groups are too well known to need definition.

DIFFERENTIAL DIAGNOSIS

Using the classification in the last column, the major points of differential diagnosis are presented in Table 2, the most important points for differentiating these syndromes being underlined.

TABLE 1.—*Classifications of Toxemias of Late Pregnancy*

American Committee on Maternal Welfare	Stander (90) cases	Dieckmann (1100 cases)	A* (280 cases) 8.3%	B* (56) 3%
Preëclampsia	Low reserve kidney	Preëclampsia	Preëclampsia, 63%	64%
Mild	68%	47%	Mild, 111	27
			Moderate, 48	9
Severe	Preëclampsia 9%		Severe, 17	0
Eclampsia	Eclampsia	Eclampsia	Eclampsia, 8.6%	10%
Convulsive	4%	4.4%	Mild, 17	6
Nonconvulsive			Severe, 7 (3 deaths)	0
Hypertensive Disease				
a. Benign		Essential	Essential	
1. Mild		hypertension	hypertension, 10.8%	10%
2. Severe		12%		
b. Malignant	Chronic Nephritis 19%		"Posteclampsism Toxemias", 14.4%	10%
Renal Disease				
a. Chronic vascular nephritis		Vascular-renal disease		
b. Glomerulonephritis		36%	Chronic glomerulo-	
c. Nephrosis			nephritis, 3.2%	2%
d. Other forms				
Unclassified (Cases excluded because of incomplete data or indecision)	10	572	40	1

*Series A represents the distribution of 280 consecutive cases of hypertension in pregnancy during one year at the Los Angeles County Hospital. Series B represents 56 consecutive private cases of Dr. Clarence W. Page during a ten-year period. In all columns, the unclassified cases were excluded before calculating the frequent percentage.

PROPHYLAXIS

In vascular, or renal diseases, existing prior to pregnancy, the only available prophylaxis is the prevention of pregnancy, or its early interruption in severe cases.

The only proven prophylaxis of eclampsia is the early detection and prompt treatment of preeclampsia. The mild grades of preëclampsia appear in spite of rigid observance, especially in short, pyknic overweight women with evidences of endocrine disturbances. The only measure of probable value is the strict control of the sodium and water balance during the last trimester of pregnancy in those women showing edema or rapid weight gain. True weight gain (as represented by the body-weight on the tenth postpartum day, minus the body-weight at the beginning of pregnancy), is probably not correlated in any way with the development of toxemias. The higher incidence of severe toxemias (and deaths) in women who do not have prenatal care is due for the most part to the failure in starting them on a therapeutic régime early enough to interrupt the progress of the disease.

Outline of treatment follows:

I. PREECLAMPSIA

Method of Grading Severity:

It is quite important to grade the seriousness of preëclamptic toxemia before instituting treatment. Individual estimates vary widely, and the following objective method has proven to be of considerable value.

(a) Add systolic and diastolic pressures, and subtract 230 (i.e., the sum of 140/90).

(b) To this figure add 10 for each "plus," or each gram of albumin up to 40 points.

(c) List the symptoms for the past 24 hours and add the folowing points, depending on your estimate of their severity.

Headache	10, 15 or 20
Visual disturbances	5, 10 or 15
Edema (hands or face)..	5 or 10
Nausea and vomiting....	5 or 10
Epigastric pain with liver tenderness, or jaundice	25 or 50

The sum constitutes the "toxemia index." An index below 20 is negligible; 20-50 = mild; 50-100 = moderate, and over 100 = dangerously severe. This system is applicable only to preëclampsia and, while seemingly complicated, has proven (over the last seven years), to be of prognostic value. Daily tabulations will give an accurate indication of progress.

A. *Treatment of Mild Grades:*

1. Single room. Blood pressure twice daily. Daily qualitative albumin determination on voided morning specimen. No blood chemistry necessary.

2. Fluids—1500 to 2000 c.c. in 24 hours. Chart intake and output.

3. Salt-poor (i.e., less than 3 gms.), soft diet. No baking soda.

4. Phenobarbital, gr. ½ or 1 t.i.d.

5. Milk of magnesia each night, sufficient to maintain free elimination. Antepartum cases, if in the hospital, may be discharged 24 hours after symptoms of toxemia have subsided, though treatment should continue. *Patients showing no improvement after 48 hours should be treated as of moderate grade severity.*

6. Mild saline catharsis.

7. If systolic blood pressure should exceed 170, or diastolic exceed 115, give 20 c.c. of 10 per cent magnesium sulphate intravenously (very slowly), and repeat in 2 to 4 hours if necessary.

8. *Ordinarily, labor should be induced if the severity is not lessened to a mild grade within 48 hours.*

TABLE 2.—*Differential Diagnosis of Hypertension in Pregnancy*

	Preëclampsia and Eclampsia	Essential Hypertension	"Posteclampsism toxemia"	Chronic Nephritis
Parity	Majority primiparae	Majority multiparae	Multiparae (by definition)	Majority multiparae
Family History	0	Significant	0	0
History of Hypertension	0	Usually	Only in late pragnancy	Often
History of Nephritis	0	0	0	Usually
History of Eclampsism	0	Recurrent "toxemias"	Always (by definition)	Recurrent "toxemias"
Edema	Usually	Rare	Rare	Slight
Headaches	Often constant and severe	Throbbing, mild, occipital	Rare	?
Visual Disturbances	Acute	Chronic and uncommon	Uncommon	Chronic
Epigastric Pain	In severe cases	0	0	0
Convulsions	In eclampsia (by definition)	Eclampsia occasionally superimposed. Otherwise, convulsions rare.		Only with uremia
Onset of Symptoms	3rd trimester	Before, or in first half of pregnancy	2nd half of pregnancy	Before or in 1st half. Abortion common
"Personality Type"	Average	"Hypertensive make-up"	Average	Average
Eyegrounds (severe cases)	Edema and acute h. t. retinopathy	Chronic h. t. retinopathy	Usually mild	Chronic retinopathy
Lability of B. P.	Marked	Marked in early cases; not in late	Marked	Tends to be constant
Cold Pressor Test	Average (?)	Hyperreactive	Usually hyperreactive	?
Albuminuria	Mild to severe; acute	Absent or mild	Absent or mild	Chronic. (Also casts and r. b. c.
N. P. N. or Urea	Usually normal	Normal	Normal	Elevated
Blood Uric Acid	Elevated in proportion to liver damage	Normal	Normal	Elevated only in proportion to other metabolites
Concentrating Power of Kidney	Usually normal	Normal except in severe types	Normal	Usually impaired
B. P. on Following Examinations	Normal	Elevated and progressive	Normal	Usually elevated

B. *Moderate Grade of Severity:*

1. Single room, and no visitors. Quantitative albumin determinations on morning urine specimens. Request blood N.P.N. and total serum proteins. Examine eyegrounds.

2. Fluids—1500 to 2000 c.c./24 hours. Accurate record of intake and output.

3. Salt-poor, low fat, high carbohydrate and high protein diet. Give dextrose in lemon juice between meals.

4. Sufficient sedation to keep patient slightly drowsy.

5. If edema is present, give ammonium chloride (preferably enteric coated), 4 to 6 grams (e.g., gr. xxx t.i.d. p.c.), for three to five days.

(*Comment:* This acts as a diuretic, and the ammonium ion is converted to urea, leaving the chloride ion to take up sodium from the sodium acid carbonate in the blood. The sodium chloride is excreted in the urine.)

C. *Severe Grades:*

Treatment is the same as that outlined below for eclampsia. *Pregnancy should be terminated by the most conservative means, if the severity is not lessened to a moderate grade within 24 hours.*

(*Comment:* In all toxemia cases, the patient may usually be returned to a normal régime by the fourth day postpartum, especially if active diuresis has occurred.)

II. ECLAMPSIA

Method of Grading Severity (Dieckmann):

The criterion for severe eclampsia is the presence of one or more of the following findings:

(a) Persistent coma; (b) temperature of 103 degrees or more; (c) pulse rate over 120; (d) respiratory rate over 40; (e) more than ten convulsions; (f) cardiovascular impairment, as evidence by pulmonary edema, persistent cyanosis, low or falling blood pressure, or weak pulse; and (g) the failure of medical treatment to stop convulsions, or to produce a diuresis of at least 700 c.c./24 hours or to overcome coma.

General Management of Patient:

1. Absolute rest in a darkened room, with sideboards on the bed and a constant attendant. Minimum handling of patient. Do not disturb with enemas, lavages or repeated manipulations. Leave B.P. cuff on arm. Turn patient on her side if she is in coma. Protect tongue from injury (but do not try to force tongue blades between teeth after a convulsion has started). Have a bulb at hand for aspirating mucus from throat.

2. Use oxygen tent if available; if not, give inhalations of oxygen during, and for five minutes after each convulsion.

Procedures:

3. Take B.P. hourly (or oftener), during acute phase; later, every three hours, if systolic pressure is over 150; otherwise twice daily. In antepartum cases check fetal heart tones each time blood pressure is taken.

4. Daily quantitative albumin determination until fourth day postpartum. Microscopic examination of catheterized specimen shortly after entry.

5. Chart intake and output daily. Physician is to be notified if output falls below 500 c.c./24 hours.

6. Type for transfusion (for use in the event of hemorrhage or shock).

7. Request the following blood chemistry: N.P.N., serum proteins, uric acid, and CO_2 combining power.

8. Examine eyegrounds (but not during acute phase, for sudden light may precipitate a convulsion).

9. Obtain a consultation on cases of eclampsia for your own protection.

Diet and Fluids:

10. Nothing by mouth except water until eight hours after convulsions have ceased; then order a soft, highcarbohydrate, high protein, neutral or acid ash and low salt diet.

11. Give between 1500-2000 c.c. fluids in 24 hours. (This includes parenteral fluids.)

12. If total proteins are below 5.0, or if diuresis fails to occur within a reasonable time, give a plasma or serum transfusion.

(*Comment:* Remarkably good results may be obtained even though the serum proteins are not elevated by the transfusion.)

Medications:

13. Give 20 c.c. of 10 per cent magnesium sulphate on entry, after each convulsion, or when systolic pressure exceeds 150; *but* do not give more often than once an hour, nor more than eight injections in one day. Test knee-jerks before each injection, and, if absent, do not give magnesium sulphate. If anuria is present, do not give more than one injection.

(*Comment:* The therapeutic results of intravenous magnesium sulphate depend upon attaining sufficient blood concentration to relax arteriolar construction. Excretion is entirely through the kidneys; so that severe oliguria may result in cumulative effects. Calcium is an immediate antidote for medullary depression. Since calcium likewise relaxes arterioles, infusions of a combined magnesium lactate and calcium lactate solution are being tried experimentally.)

14. On entry, give 200 or 250 c.c. of 25 per cent dextrose in distilled water (not in saline or Ringer's solution). Give three or four times daily during acute phase of toxemia.

15. If convulsions do not cease following intravenous magnesium sulphate, give (a) 8 to 12 c.c. of paraldehyde by deep intramuscular injection (or 15 to 30 c.c. rectally), or use (b) sodium phenobarbital gr. v (or sodium amytal gr. v) intramuscularly, repeating in 8-12 hours if necessary. Do not use opiates or intravenous barbiturates.

16. Give mild saline cathartics for free elimination.

Treatment of Complications:

1. *Acute pulmonary edema.*—Fowler's position, tracheal suction, oxygen, digoxin or digilanid intravenously. Inflate cuffs on three extremities to 110 mm., or remove 300-500 c.c. blood.

2. *Acute vascular collapse.*—(Systolic B.P. below 90). Trendelenberg position; caffeine or ephedrine; start 5 per cent glucose in distilled water and follow as soon as possible with blood or plasma.

3. *Anuria.*—Give 50 c.c. of 50 per cent dextrose intravenously. (Give slowly and avoid leakage.) Repeat as indicated.

Obstetrical Management:

In antepartum cases, as soon as the patient improves or becomes stationary (ordinarily within 15 hours after treatment is started), labor should be induced, usually by rupture of membranes. If the patient is less than eight months' pregnant, or if there is cephalopelvic disproportion, a cesarean section under local or cyclopropane anesthesia may be the most conservative means of delivery. Cesarean section, however, is not done for eclampsia alone. Do not use pituitrin (because of its pressor and antidiuretic fractions). If necessary, use pitocin.

UNDESIRABLE METHODS

Other drugs and procedures used in the treatment of eclampsia are almost too numerous to mention. Certain ones, such as purging, colonic lavage, sweating, and routine ureteral drainage, are meddlesome. Nitrites, thiocyanates and mercurial diuretics have been tried and found to be dangerous. Veratrum viride is still used in a few

places, but is a powerful cardiac depressant and has been discarded by most authorities. Spinal drainage does not relieve true cerebral edema and may damage medullary centers by downward expansion of the brain. All sodium salts in appreciable amounts are contraindicated. Forcing fluids during the acute stages of toxemia is dangerous, and extreme dehydration reduces the urinary output and may result in the prerenal accumulation of metabolites. Ether and chloroform may add insult to a damaged liver. Opiates in average doses do not control eclamptic convulsions, and in large doses actually increase the spinal reflexes and depress the respiratory center. The endocrine therapy of preëclampsia and eclampsia is in a highly unsettled and experimental stage, and the use of hormones in this disease is not at present on any rational basis.

III. ESSENTIAL HYPERTENSION, POSTECLAMPSISM TOXEMIAS AND CHRONIC GLOMERULONEPHRITIS

In all three of these diseases, the treatment is similar and is essentially the same as the accepted medical management outside of pregnancy: for example: rest, continuous mild sedation, salt-poor diet, and in the presence of renal insufficiency, low protein intake. Pregnancy *per se* does not create an added excretory load for the kidneys, as commonly believed. Women with preëxisting renal or vascular diseases, however, are more likely to develop a superimposed preëclampsia, in which case the treatment is like that outlined above. The first indication of this is usually a sudden increase in albuminuria and edema. Women with essential hypertension have an even chance of going through pregnancy without an exacerbation. The most important consideration in each of these three syndromes is the decision as to when to terminate pregnancy. The rare case of malignant hypertension, or of chronic glomerulonephritis with renal insufficiency, should have a therapeutic abortion. Late in pregnancy, any hypertension which shows a steady increase and is accompanied by any degree of albuminuria will, in a very few weeks, cause irreversible vascular damage. This fact must be borne in mind in considering the time for inducing labor.

IN CONCLUSION

Questions involving the etiology of eclampsia, or any other of these hypertensive disorders of pregnancy, have been purposely avoided. Until we learn the basic causes, mothers will continue to die from these complications, and until we learn those causes, there can be no specific therapy. Our treatment must remain on a physiologically, rational, symptomatic basis.

2560 Bancroft Way.

Man's intellectual and spiritual destiny is in no small degree determined by what and how he reads. As reading is a mark of civilized peoples, so is it of individuals who grow and progress. Its importance, which arose with the art of writing, mounted rapidly after the invention of printing, and reached its present climax through the wide diffusion of books.—Leon J. Richardson.

MEDICAL EPONYM

Argyll Robertson Pupil

Although he credits Stellwag von Carion with the statement that tabes dorsalis and spinal paralysis may cause paralytic myosis, the account of the rigid pupil in his report, entitled "On an Interesting Series of Eye-symptoms in a Case of Spinal Disease, with Remarks on the Action of Belladonna on the Iris, etc.," in the *Edinburgh Medical Journal* (*14*:696-708, 1869), together with a later report, "Four Cases of Spinal Myosis; with Remarks on the Action of Light on the Pupil," in the same journal (*15*:487-493, 1869), has served to affix permanently the name of Douglas Argyll Robertson (1873-1908), lecturer on diseases of the eye at the University of Edinburgh, to this phenomenon. The following quotation is from the earlier article:

"On examining the eyes, I found both pupils contracted to little more than pin-points, the right rather the smaller of the two. . . . I could not observe any contraction of either pupil under the influence of light, but, on accommodating the eyes for a near object, both pupils contracted."—R. W. B., in *New England Journal of Medicine*.

'Chutist Tells How It Feels to Fall 5½ Miles in Two Minutes.—Two impression packed minutes in which Arthur H. Starnes, veteran stunt flyer, fell five and a half miles before opening his parachute were described tonight. Starnes did not lose consciousness. He felt no physical effects.

The Northwestern University Medical School tonight made a full report on the delayed jump in which Starnes stepped out of a plane 31,400 feet in the stratosphere loaded with equipment which measured his heartbeat, the speed of his fall, body spins and effects of atmospheric pressure.

For 29,300 feet Starnes tumbled through the air in a free fall that lasted 116.5 seconds. At 2,000 feet he pulled the rip cord on his parachute and took another two minutes to float leisurely to the ground.

A log of Starnes' tumble read like this:

31,400 feet—Stepped from plane flying 171 miles per hour. Fall began at rate of 43 miles per hour with a horizontal movement caused by the speed of the plane.

30,200 feet—Now falling 199 miles an hour downward.

28,850 feet—Had fallen almost half a mile. Time elapsed, 19.1 seconds. Slight body spin, spin cut fall to 170 miles per hour. . . .

23,200 feet—Passed through cloud. Goggles frosted outside.

21,750 feet—Kicking out of spin and staying belly down to present maximum body surface to increasing atmospheric pressure cut fall to 179 miles an hour; 42.1 seconds gone. . . .

3,170 feet—Speed 188 m.p.h. Pulled up frosted goggle to look at altimeter to determine when pull rip cord. Glanced at ground, realized in flat spin. Sensation dizziness. Transiently nauseated.

2,100 feet—Pulled rip cord.

Starnes said that he at no time felt like he was hanging in midair. The veteran jumper made five other test jumps from lesser heights for the four physicians conducting the experiments—Dr. Andrew C. Ivy, Dr. Louis R. Krasno and Dr. Albert H. Andrews of Northwestern University, and Dr. Anton J. Carlson of the University of Chicago.

He wore a special oxygen mask and an electrically heated suit. A short wave radio broadcast his heart beat to a recording disc on the ground below.—San Francisco *Chronicle*, December 11.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals: For Colleagues in Military Service

In former issues appeared editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

Medical journals and books may be sent to any of the addresses listed below:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261).

I

The Pepper Hearings on Medical Manpower

The Procurement and Assignment Service for Physicians, Dentists and Veterinarians, established as a part of the War Manpower Commission, is carrying on a scientific, carefully considered allocation of physicians, dentists and veterinarians to meet the needs of the armed forces, industry and the civilian population, as directed by the President of the United States in his order establishing this body. Nevertheless, a small group of individuals, including a few physicians, apparently dissatisfied with actions of the Procurement and Assignment Service in some instances, was mustered to appear before a subcommittee of the Committee on Education and

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

Labor of the United States Senate for hearings now being held in Washington. The American Medical Association was represented only on its own request. Obviously the American press has not been able to reflect fully the various facets of what some newspaper men have described as a "one-man inquisition," conducted by Senator Pepper. *The Journal* hopes in future issues to print a rather full account of the hearings. Physicians may then judge for themselves the nature of the inquiry and the end apparently sought.

One of the chief facets thus far obvious is the desire of some industrial leaders and of the full time staffs of physicians which they employ to maintain their individual empires without disturbance regardless of the needs of the armed forces for physicians. They believe apparently that individual physicians should be taken by the armed forces before clinics, private hospital staffs, industrial organizations or similar groups are in any way disturbed. The first objective of the nation is the winning of the war. The armed forces require preferably physicians under 40 years of age. The decision as to who is physically fit or unfit for military service and as to who is "essential" or "not essential" cannot be left to the opinion of the individual physician himself or to the organization which employs him.

The statements of Dr. Frank H. Lahey, chairman of the board, and of Dr. Max E. Lapham, director of the Procurement and Assignment Service, placed clearly before the Pepper "inquisition" the facts regarding the number of physicians in the United States, their availability for various types of service, the procedures that are being followed in protecting industry and civilian communities against a shortage of medical manpower, and the absolute impartiality with which the affairs of the Procurement and Assignment Service are being administered. Some witnesses tried to force the concept that the personnel of the Procurement and Assignment Service with all its widespread organization throughout the nation, including the corps area boards and the state and county officials, all of whom contribute their services without remuneration, are creatures of the officials of the American Medical Association. Some representatives were charged with utilizing their positions to interfere seriously with the orderly functioning of American medical practice and indeed to injure the public health. The concept is itself as false as many of the other insinuations that were made by some of those who testified. This will be clear to every physician who studies this testimony when it is printed.

Prime movers in this assault on the Procurement and Assignment Service and perhaps also on the War Manpower Commission, of which it is a part, are, as will be obvious from the testimony, Paul de Kruif, Ph.D., Michael M. Davis, Ph.D., Mr. Henry J. Kaiser, eminent industrialist, the head of his medical services, Dr. Sidney Garfield, and two physicians who are said to have been heard in executive sessions of the committee and whose names are thus far not available. Accompanying Senator Pepper in his conduct of the "inquisition" are two economists, most of whose questions, as will also be clear in the published testimony, are directed toward establishing the view that American medicine has failed to meet its obligations in the war effort and that some agency must be established with totalitarian control over all medical facilities.

In his testimony before the hearings, Dr. Thomas Parran, of the U. S. Public Health Service, spoke strongly in behalf of the services being given by the medical profession in this time of the nation's need and stated without the slightest equivocation:

SENATOR PEPPER: Do you think that allocation of medical personnel between military services and civilian work should have been handled through the Public Health Service rather than through the Procurement and Assignment Service?

DR. PARRAN: I think the present arrangement is the best. As a matter of fact, after seeing the system as it was set up in Great Britain eighteen months ago, I discussed that system with the Health and Medical Committee and others and perhaps was responsible to some extent for a separate group representing the medical and dental professions being set up to deal with this problem.

Nevertheless, "Ph.D.s" de Kruif and Davis do not hesitate to endeavor to force on the U. S. Public Health Service a responsibility which the Surgeon General of that service certainly does not seek and which is opposed to his own statement based on serious study and established knowledge, that he considers the present method "best."

Already evidence has been submitted that the services established by Mr. Henry J. Kaiser, under the direction of Dr. Sidney Garfield, are endeavoring to hold from the armed forces even the opportunity to determine for themselves whether or not the considerable number of young men employed on salaries by this industrial organization are fit and available for military service. Certainly the decision as to whether or not these young men may best serve the nation in time of war in the armed forces or in the civilian capacities which they now occupy cannot be left to their employers. The final responsibility does not rest on the Procurement and Assignment Service, which can only indicate its belief as to whether or not such men are essential. The decision rests—and wisely—with the local boards in the areas concerned; these boards may give consideration to the recommendations made by the Procurement and Assignment Service. From the decisions of the local Selective Service boards appeal may be made, according to conditions established by our government, even as high as the national agencies in Washington or the President himself. Every young physician in the United States under 40 years of age should now determine in his own heart and in the light of the principles of public service traditional in medicine, whether or not he is doing his utmost to serve the nation in this time of emergency.

When the transcript of the hearings is published in forthcoming issues of the *The Journal*, readers may determine the extent to which the hearings conducted by Senator Claude Pepper of Florida represent a courteous effort on the part of a public official to determine the facts, so that representatives of the people may legislate wisely to meet the needs of the hour, or whether or not a public agency, namely a senatorial hearing, is being used—or abused—under the leadership of a senator, to pillory a profession. Already that profession has contributed to the armed forces more than forty thousand physicians, the very best that the nation can supply. The remainder are working without thought of hours, of exposure, of fatigue or of recompense to maintain medical service for the American people in this time of trial. The performance displayed in Senator Pepper's hearings is not likely to improve the morale of American medicine at the very time when it should be at its highest in the service of the war effort.—Editorial in *Journ. A.M.A.*, Nov. 14, 1942.

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II

The Pepper Hearings on Medical Manpower

Immediately following the editorials in this issue of *The Journal* [November 21, pp. 927-966], appears the report of the hearings before the Pepper Subcommittee on Education and Labor dealing with medical manpower.

A preliminary editorial on the subject was published in *The Journal* last week. Almost simultaneously with these hearings appeared an editorial in the New York *Times*, a public statement by Michael M. Davis, a press release by the so-called New York Physicians' Forum, a group of some one hundred and thirty physicians in New York City. This group includes among its leaders Drs. Ernst P. Boas and Miles Atkinson. Physicians will remember the recent appearance of these two physicians on a forum held in Washington and their insistence on a revolution in the nature of medical practice. Even before the United States entered the war, the prediction was made by many physicians that attempts would occur to utilize the emergency as an excuse for radical changes in the administration of medical services in this country.

In the report of the hearings which follows, attention is called particularly to certain highlights which merit special consideration. Dr. Frank H. Lahey placed before the committee the present status of the Procurement and Assignment Service and indicated some of the difficulties involved in the work which it is conducting. Senator Hill was exceedingly courteous to Dr. Lahey, although somewhat later in the hearings Senator Pepper intimated that Dr. Lahey is merely an automaton or marionette functioning at the behest of the Army and Navy. This will no doubt surprise Dr. Lahey.

Dr. Thomas Parran attempted to state the exact situation as he observed it. Both the Senator and his economist advisers seemed to be much annoyed that Dr. Parran did not adopt the words which they endeavored to put into his mouth.

Paul de Kruif, Ph.D. in bacteriology, indicated that he had not made any personal investigation of the Procurement and Assignment Service or of its work and that he was speaking largely from hearsay. He did draw into the situation the case of Dr. Tom Spies. Immediately following the publicity accorded to this incident, the editor of *The Journal* called Dr. Spies on the telephone. According to what Dr. Spies reported, it was the belief of a friend and preceptor that Dr. Spies should be in military service; apparently this friend asked de Kruif to speak to Dr. Spies on the subject. This was the widely publicized incident which de Kruif characterized by saying that the American Medical Association had "put the finger" on Dr. Spies. The evidence indicates that de Kruif is dissatisfied with the American Medical Association or those whom he characterizes as its leaders, although the specific cause of his annoyance is not made clear.

Mr. Henry J. Kaiser and the director of his medical services, Dr. Sidney Garfield, claim to have had some difficulties with the local representatives of the Procurement and Assignment Service because of their desire to hold in their permanent organization young physicians who have been marked "available" by the Procurement and Assignment Service.

Senator Pepper did not permit the editor of *The Journal* to make any formal statement. The hearing was conducted wholly by the question and answer technique. This procedure Senator Pepper followed frequently with all who appeared, so that much of the hearing is devoted to long statements by Senator Pepper with the answer "Yes, sir" and "Certainly, sir" from those who were supporting the cause in which the hearings were held. The editor of *The Journal* apparently found it difficult to say "Yes, sir"; it will be observed that he frequently said "No, sir."...

Mr. Michael M. Davis, Ph.D., presumably in economics, spoke as was expected.

It will be interesting to see what kind of report the Subcommittee on Education and Labor makes to its full committee. There is apparently an effort on the part of this senatorial group to set up an independent agency for the control of all manpower, with Mr. Henry Wallace, vice-president of the United States, as its head. Presumably they would take authority from the Selective Service System and from the present War Manpower Commission as now constituted and make all agencies subservient to what Senator Pepper calls an "over-all" committee.—Editorial in *Journ. A.M.A.*, Nov. 21, 1942.

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Excerpts from "Pepper Hearing" at Washington, D. C., November 2, 1942. (Reprinted from Jour. A.M.A., issue of Nov. 21, 1942.)

Interrogation of Morris Fishbein, M. D.

SENATOR PEPPER: *What do you regard as the essential needs of the armed forces, how many doctors per thousand men?* DR. FISHBEIN: I say now that they are asking 6.5 men per thousand. But if they reduce that to what Great Britain has, 4.5 per thousand, there would still not be enough young doctors to meet their needs if young doctors, men under 37 years of age, take jobs in industry in order to avoid military service.

SENATOR PEPPER: *Are there any doctors in the armed service engaged in administrative work?* DR. FISHBEIN: By a joint directive from the Joint Army and Navy Board, both Army and Navy medical departments have been instructed to take from the desk every doctor capable of giving medical service in the field.

SENATOR PEPPER: *Well now, Doctor, suppose that you should find doctors occupying key places in industry, that is the maintenance of the health of the employees of companies that build ships and cannon and airplanes and the implements of war, then it would be the old question of determining which is more important, the man or the gun, wouldn't it?* DR. FISHBEIN: Senator Pepper, that question has been given the most careful consideration by groups of the leading industrial physicians in the United States, and I mean the industrial physicians for organizations as large as General Motors, du Pont, Chrysler and Ford. All these men who are the leading industrial physicians in the United States have sat on these boards, which are making the decisions as to what constitutes an essential physician in industry.

Considering this matter purely as a matter of general information, the kind of knowledge that any man can have, it is quite obvious that a man who has built up an industrial organization for a great industry of the scope of General Motors or du Pont, and who has all of his physicians of various grades and specialties rendering service, does not wish, in wartime, to see one man moved out of that job.

We didn't like the idea of taking what I would say were seven key men from the headquarters of the American Medical Association because we have to take in other men, older, and train them to fit jobs for which we have trained men for ten and fifteen years. But we made a decision very early that if the armed forces needed a man he was to go, and we would take an older man and train him in the job.

SENATOR PEPPER: *Now who knows more about the public health, the armed forces or competent people who have the responsibility for the maintenance of our industrial operations, and the people who are in direct touch with the public health?* DR. FISHBEIN: I would agree with you at once that the leading industrial physicians of the United States know much more about industrial medicine than I do, and these decisions have been made by the leading physicians in industrial medicine in this country.

SENATOR PEPPER: *You mean the decisions in a local draft board?* DR. FISHBEIN: I mean the decisions having to do with the standards which should determine whether or not a physician in industrial medicine was or was not an essential man in that position.

SENATOR PEPPER: *Well, now, the man who is the head of a particular medical unit would also have some very important knowledge on that subject, would he not?* DR. FISHBEIN: The man who is the head of that unit, this being a democracy, has open to him four or five different methods of approach for carrying his problem to the highest point, namely Washington. He can carry his problem to the national Selective Service System. When a draft board takes a man whom he considers essential, he is privileged to file an appeal; he can carry that to his appeal board; he can carry it from the appeal

board to the national Selective Service System. And specifically, if there are 11 doctors under 37 years of age employed in any hospital associated with an industry, and if a draft board takes any 1 of those 11 who are essential to that industry, the man in charge has two methods by which he can retain the man. The man can appeal and the industry can appeal on his behalf, that is through the draft board route. Now through the Procurement and Assignment route he can again appeal to the state procurement officer; from the state procurement officer he can appeal to the corps area procurement board; from the corps area procurement board to the national board of Procurement and Assignment, on which the final decision would rest. Now if no such appeal has come up on behalf of any man from the agency that wants to keep the man, the fault cannot rest with the agency at the top, it must rest with the man who failed to file the appeal.

SENATOR PEPPER: *You mean that that is one of the methods he may pursue. Can you tell us how many men regarded as essential to the maintenance of health facilities have been kept out of the clutches of Selective Service by any of the Procurement and Assignment officials?* DR. FISHBEIN: Many hundreds.

SENATOR PEPPER: *Give us your best estimate?* DR. FISHBEIN: I wouldn't like to give an estimate, but I will file a definite statement with you as soon as I investigate the matter.

SENATOR PEPPER: *All right, we will be glad to receive that.* DR. FISHBEIN: I would have to make a special investigation on that point, but I can have the information for you.

SENATOR PEPPER: *Now in the various counties I believe you said there were representatives of the Procurement and Assignment Service?* DR. FISHBEIN: In some, not in all. There are, for instance, eight counties in the United States with less than 5 people to a square mile. No one attempts to handle that situation by setting up an organization. In some two thousand counties there are probably men who would act for the Procurement and Assignment Service, or committees of men, in grading doctors as essential or as not essential.

SENATOR PEPPER: *Dr. Lamb has some questions.*

DR. LAMB: *In connection with your point of a moment ago, Doctor, essential physicians in industry such as you were describing are not limited to those employed specifically by the large industries; that is to say, the health of industrial workers depends very largely on the average individual physician in a given community, or a member of a hospital staff, or what not?* DR. FISHBEIN: Yes, sir.

DR. LAMB: *Appeals on individual cases in other parts of the Selective Service, which I think this committee has already determined are not well protected by the present occupational deferment machinery, are no substitute for the good working of a system in which the overall plan is adequate—you would agree with that?* DR. FISHBEIN: That is absolutely right.

DR. LAMB: *So that your statement of a moment ago that these deferments might be secured for individuals is not, in your estimation, any substitute for the adequacy of the plan?* DR. FISHBEIN: Oh no. To move on to that next step which you have just raised, I am convinced that there must be and will be—of course if this war lasts—an overall control over all professional and trained personnel. There must be, because in no field is there a sufficient number of men to meet the special needs created by an army of the size proposed.

DR. LAMB: *Right on that point, we have at the present time about 40,000 physicians, you said, in the armed services?* DR. FISHBEIN: Yes.

DR. LAMB: *And I take it from what you said that they are the great majority of those under 40?* DR. FISHBEIN: Yes, it is about half of those under 40. The average age of graduation is 28 years, and they graduate each year between 5,500 and 6,000 doctors. They take one year of internship before they are considered competent, and then if they care to go into a specialty they must take a residency. All that is being looked after, that is the maintenance of a minimum number of residents, and the maintenance of a minimum number of interns—that has all been given thought. In the twelve year period it would give you 72,000 doctors under 40, which is just about right.

DR. LAMB: *Now if we have seven and a half million man army, as stated by Secretary Stimson as the goal for 1943, that would mean that if all those who are serving in the armed service are in that category of under 40 you will have all of the doctors of that age; is that correct?* DR. FISHBEIN: Fortunately for us they are not all under 40 and the exact figures are available as to just how many are now in the armed forces and in the civilian population, under 40 and above 40.

DR. LAMB: *Would you give them to the committee?* DR. FISHBEIN: I will leave them with you. For every five year age group beginning with the first year of the medical school and upward, as high as they go, we have all the doctors of this country classified—

DR. LAMB: *Dr. Lahey testified that out of that 176,000 you would not classify more than 120,000 of them as effective physicians.*

DR. FISHBEIN: That is, effective for all purposes. Now we classify, for example, a bare 30 per cent of the men over 65 as effective for all purposes, and when you get over 70 that would drop still further. Under 35 years of age, 42,671 physicians; from 35 to 44, 41,558 physicians; from 45 years to 54, 31,399 physicians. Now that gives you, let us say, under 45 about 84,000 doctors, effective doctors, in the country, and they would be considered, let us say, effective for all purposes, the men under 45 years of age.

DR. LAMB: *What part of those are included in the 40,000 or more in the armed forces?* DR. FISHBEIN: I would say that the large majority of them are included in the 40,000, but you see there is a total there of 85,000 doctors, so there is still half of those left.

DR. LAMB: *In other words we have approximately 45,000 doctors, or less, now available and considered to be in their prime, for the service of 120,000,000 people?* DR. FISHBEIN: Again that is not quite right for the simple reason that the age period from 45 to 55 gives you 32,000 doctors and from 55 to 65, 30,000 doctors. Now the effective age for the civilian population, perhaps the best age for the civilian population of the doctor is 55 to 65.

DR. LAMB: *If I may interrupt, you have now given us 143,000 doctors under 65, and a moment ago we were discussing the possibility that only 120,000 physicians in the country were effective, and that gives us at least 23,000 who are not in the effective class.* DR. FISHBEIN: If you want to class all of the officers of the United States Public Health Service as not in the effective class—

DR. LAMB *(interposing): We are concerned with their effectiveness for the purpose of caring for the civilian population and your figure of 1 to each 1,500 was based on that. . . .*

DR. LAMB: *Thank you. Will you state your corrections?* DR. FISHBEIN: You are assuming, in the first place, that the American Medical Association drew up plans for controlling the overall distribution of the medical profession in the United States, and they didn't.

DR. LAMB: *I am not assuming anything of the sort.* DR. FISHBEIN: It is in your question, if you will have the record read.

DR. LAMB: *I am assuming that originally the plans worked out for Procurement and Assignment are those which were worked out through the operations of your county by county and state by state estimating system, is that correct?* DR. FISHBEIN: They declared certain doctors available and certain doctors unavailable, but—

DR. LAMB *(interposing): And this is the framework under which Procurement and Assignment has gone on. What sort of protests has the American Medical Association made with respect to the continuation of enlistment of doctors?* DR. FISHBEIN: There have been letters that have gone forward to the Surgeon General of the Army and to the Secretary of War. As rapidly as it appeared that in certain areas the condition was becoming what would ordinarily be called tight, authorities representing the armed forces were informed of the fact that in certain areas of the country conditions were becoming tight and that some action should be taken. But that action had to be taken by federal agencies.

DR. LAMB: *But no effort was made to request that enlistments stop entirely and that some other system be substituted?* DR. FISHBEIN: The withdrawal of the recruiting teams was not a matter of a single action suddenly withdrawing all the recruiting teams. Just as soon as it was apparent that recruiting should stop in certain areas, it stopped in those areas, even by direct recommendation from the corps area commander, who, under our present system of Army control has the control, in his corps area, over the recruiting teams.

DR. LAMB: *Would you testify, Doctor, that in January of this year it was impossible for the American Medical Association to foresee the effects of enlistment?* DR. FISHBEIN: I think that they were clearly understood in January of this year by the Procurement and Assignment Service.

DR. LAMB: *Were there any representations by the American Medical Association to either the Surgeon Generals or the Procurement and Assignment Service, demanding that in January enlistments should be stopped of doctors and that some other system should be substituted therefor?* DR. FISHBEIN: We are not in the habit of demanding anything.

DR. LAMB: *Were letters written along those lines?* DR. FISHBEIN: Yes.

DR. LAMB: *Will you furnish the committee with any letters to that effect written by the American Medical Association in January of this year?* DR. FISHBEIN: I think it would be more in order for you to request either the Secretary of War or the Surgeon General of the Army to produce such correspondence than to ask us to produce our correspondence with them, and I think that the Surgeon General would tell you that that matter has been looked after.

DR. LAMB: *Since this was a matter of initiative on your part it seems a correct request, but the committee, I am sure, will be glad to request that correspondence from these other sources.* DR. FISHBEIN: I am quite willing to ask the permission of the Secretary of War to send you the correspondence we had with him, if you wish to have it. I don't know where these authorities lie.

DR. LAMB: *I am sure that Senator Pepper would be glad to correspond with the Secretary of War to secure that correspondence. Now this question with respect to the ratio of 1 to 1,500: obviously that is an average and therefore has very little relationship to this 1 to 4,100 or 1 to 7,000, or whatnot?* DR. FISHBEIN: On that I agree with you.

DR. LAMB: *Yet it is your belief that quotas should be established for areas in which those ratios prevail and that further recruitment of physicians should be carried on through the Procurement and Assignment Board?* DR. FISHBEIN: On the contrary, I have stated to the Procurement and Assignment Service repeatedly, and indeed as late as yesterday, that a quota based on an overall quota for a state like Alabama, where they have one large city with a concentration of doctors in it, and a large rural area without a concentration of doctors, that the setting up of an arbitrary quota for the state of 1 to 1,500 would produce an inequitable and intolerable situation.

DR. LAMB: *You have so protested since last December repeatedly?* DR. FISHBEIN: Yes, that is true.

DR. GARFIELD: *May I ask you a question, Doctor?* DR. FISHBEIN: Yes.

DR. GARFIELD: *Why couldn't men over 40 take care of the base hospitals in a thousand or so army hospitals in this country? How many of the younger men are in active service? Are you aware of the fact that the Seventy-third Evacuation Unit has 40 of the best young surgeons in the country, it was formed in February, and from February until now they have been stationed in some small hospital in California doing nothing?* DR. FISHBEIN: I am essentially a civilian doctor and I venture to state that if you were to ask the United States Army Medical Department about the necessity for physicians in the armed forces and how it is proposed that they will use them, that the United States Army will be able to tell you why physicians must be in training.

I am asked on behalf of a physician from Boston who is a well-known, competent ophthalmologist and who had enlisted in the Army, why that physician had been three months in a hospital and in a medical unit of the Army in Alabama without seeing any eye cases. But if the tank unit with which he had been associated was at that moment in Egypt he would be seeing more eye cases than he could possible handle, and he must be trained with his unit. You can't train him in Boston to go with a tank unit when that unit starts out.

DR. GARFIELD: *Do they train him in eye work, Doctor?* DR. FISHBEIN: They train him primarily in the functions of a medical officer in the Army. As far as I know —and again I am no authority on military medical service—it becomes essential in operating the armed forces to train men with the units which they are to accompany. You can't train a man in one place and then order him to the unit when the unit goes into battle.

DR. GARFIELD: *Isn't it true that there are forty base hospitals being built in this country, with innumerable army hospitals throughout the country, and couldn't doctors over 45 man those hospitals?* DR. FISHBEIN: They not only could, but there are many, many doctors over 45 doing that. I have seen a urologist whom I know to be 57 years of age working in one of those hospitals. I have been in areas in Florida, in army areas, within the past year, where I have seen gynecologists operating on soldiers. Those gynecologists enlisted in the Army. They were men well over 45 years of age, and they were enlisted with the definite idea that they would be retained in this country.

But again if we must have young men with the Army, if we must have men under 37 years of age, or at least under 40 years of age, to meet modern condition of warfare, and if the needs of the Army in combat are to be met, some overall agency must be concerned with utilizing the supply of young men and replacing them, as far as possible in civilian life and in the whole area, with older men. That is scientific handling of the men.

This is as good a time as any to correct a complete misstatement of fact. The policy has been adopted by the Procurement and Assignment Service, by the War Manpower Commission and, after adoption by them, approved by the American Medical Association, for the setting up of prepayment plans in all industrial areas where the needs of a rapidly growing industrial community demand that as the most efficient way of rendering medical service.

DR. LAMB: *Doctor, when was that adopted?* DR. FISHBEIN: That was adopted by the Procurement and Assignment Service Board at least three months ago; it was adopted by the Committee on War Participation of the American Medical Association about two and a half months ago; it was adopted by the Board of Trustees of the American Medical Association in the second week in September.

DR. LAMB: *Has it yet reached the Procurement and Assignment local offices?* DR. FISHBEIN: It was given out to the public and was given out to all agencies, as far as I know.

DR. LAMB: *And they are already acting on that to the best of your knowledge?* DR. FISHBEIN: To the best of my knowledge. Any one that wants to find it can have a copy of it. This is a large country and there are 120,000,000 civilians to be handled. In a service that embraces hundreds of thousands of people it is quite conceivable that some one man somewhere may not know everything that is going on. That is quite possible with respect to this man, whoever the person is, I haven't any idea with whom Dr. Garfield conferred on this matter.

DR. GARFIELD: *Three states, California, Oregon and Washington.* DR. FISHBEIN: If they will read the policy as it was adopted and has been published in *The Journal* of the American Medical Association, and released to the press and in other ways given out, the plan for meeting the civilian needs in relationship to medicine has been thoroughly discussed and carefully worked out and is already functioning in many places. I will give you if you want—I will put them in the record—the names of many areas which are already being supplied with doctors because they have a shortage of doctors, and these are being supplied by a voluntary system, by doctors who have volunteered to move to other areas, and some of them are going to such places.

MR. KAISER: *Then I take it, Doctor, you believe in prepaid medicine?* DR. FISHBEIN: I believe in prepaid medicine to such an extent that our own employees are insured under a hospitalization plan.

MR. KAISER: *And you support it whole-heartedly?* DR. FISHBEIN: I don't say all plans. I believe in prepayment plans that are set up on a legitimate basis; there are many strange plans set up on a peculiar basis.

MR. KAISER: *We are assuming that they are legitimate; we wouldn't want anything that was illegitimate. The next thing is, if you were in my position and you couldn't get your men into a hospital and you were in an area, what would you do about it?* DR. FISHBEIN: Well, it all depends. This question was asked me by another committee before which I testified recently—

MR. KAISER *(interposing): This is a specific case, we have ——— men*—DR. FISHBEIN (interposing): In the first place I believe always in operating within the law, whenever possible.

MR. KAISER: *We are agreeable to that.* DR. FISHBEIN: States have laws regulating medical practice so that it is impossible to bring a man into the state of Florida—and I mention Florida merely because that is one of the states that has the most rigid laws that exist in the country—

MR. KAISER *(interposing): I would like to get back to where I was—you will get me lost.* DR. FISHBEIN: Washington, Oregon and California.

MR. KAISER: *Yes. Here is the question exactly. I would like to get back to it because you are carrying me all over the country and I will be lost. What would you do about my specific case?* DR. FISHBEIN: If I were you I would ask my medical director to look into all the possibilities and not to try to solve the problem sitting where he is, but to go to the places where people have the information as to how the problem is to be solved.

SENATOR PEPPER: *You mean to come to you, Doctor?* DR. FISHBEIN: No sir, come to the federal agencies which are charged with this task, and that is the Procurement and Assignment Service in this case.

SENATOR PEPPER: *That are being run by the American Medical Association?* DR. FISHBEIN: Mr. Pepper, I would question that statement very strongly. If you can establish the fact—

SENATOR PEPPER *(interposing): Haven't you worked hand in glove with McNutt on this problem; you consulted with him on his speeches, didn't you?* DR. FISHBEIN: No, that is absolutely untrue. I have never seen —I can make this as a statement of fact, Senator Pepper —I have never seen in my life a speech of Mr. McNutt before it was written. I have published two of them after they were written.

DR. LAMB: *Dr. Fishbein, are you the chairman or director of information for Procurement and Assignment?* DR. FISHBEIN: I am Chairman of the Committee on Information. My purpose is to disseminate to the public—and this is the only function I have—through various press agencies and through medical periodicals the information which that agency wishes to send out.

Now, then, can you tell me any way in which the Procurement and Assignment Service could secure the cooperation and functioning of the medical profession without letting the doctors of the country know what their decisions were and how they function? Since obviously the publications which I edit, including medical and lay publications, are the best way of reaching the medical profession of the United States, the Procurement and Assignment Service would be operating inefficiently if it failed to utilize those legitimate means of publicity.

DR. LAMB: *And your services?* DR. FISHBEIN: Well, my services consist principally in this: When they send me a statement and say, "Please give this publicity," I publish it in *The Journal,* I send it to all the other medical journals of the country, and I send it to the press of the country. Now if anything can be found wrong with that procedure, anything out of the way, which indicates any control over their actions, I would like to have you point it out.

SENATOR PEPPER: *How often have you consulted with the Procurement and Assignment agency or Mr. McNutt?* DR. FISHBEIN: When they had matters of publicity to be given out they sent them to me by mail in 95 per cent of the cases. I have been present at one or two meetings where they wished me to be present in order that I might give out publicity. I do not sit with the board at their meetings.

SENATOR PEPPER: *Getting back to Mr. Kaiser's question as to what you would do in his case in trying to provide medical attention*—DR. FISHBEIN (interposing): I know that Mr. Kaiser personally is not going out to hire doctors, he is going to ask one of his subordinates to handle the matter; that is obviously Dr. Garfield. Now if Dr. Garfield had utilized methods which other men in the state of Washington were utilizing to get doctors to replace the younger men, he probably could have gotten them.

MR. KAISER: *I would like to make this point, and you will be glad to know this for your information, that in the Portland area we do have or did have that problem, but the doctors as a whole took hold of the problem themselves, organized all the hospitals and did render this service. We did nothing there, but that was not done in the other cities. Now what would you have where it was not done?* DR. FISHBEIN: What did Dr. Garfield do? Did he go beyond those people to any agency? As far as I know he has not taken the matter up directly with the national Procurement and Assignment office. Obviously if he had they are in a position to look into the picture. But I do not believe, personally, that they would be warranted in marking his young men "essential."

DR. GARFIELD: *We organized our medical service at Richmond before there was a Procurement and Assignment Service in the first place, and we chose people who we thought were ineligible for the Army as much as possible.* DR. FISHBEIN: But the Army thought differently?

DR. GARFIELD: *No, I beg your pardon, the Army now is reclassifying them.* DR. FISHBEIN: I mean the Army might think differently because they thought differently on a lot of things. The standards for the Army have changed greatly since December 7. We didn't take in men, before December 7, who had less than twelve teeth, so we had a 35 per cent rejection on account of teeth. Now we have got a 3 per cent rejection on account of teeth.

DR. GARFIELD: *We took men from all over the country, we got the best men we could. Now Procurement and Assignment says "You send all your men back to the Army and see if they want them," and that would break up our medical organization. There is one other thing. We had a shortage of beds in the area. Do you want us to go to the government and ask them for funds to build those hospitals?* DR. FISHBEIN: You have to ask them for materials, whether you ask them for funds or not.

MR. KAISER: *No, they don't give you the materials.*

DR. FISHBEIN: How do you get them?

MR. KAISER: *Priorities.*

DR. FISHBEIN: Do you know what the priority rating on hospitals is?

MR. KAISER: *It is A-1 when it comes to shipbuilding, because that is the only way you can get the doctors you are talking about, over there, by giving them a ship to go over in. I want you to get that clear.*

DR. FISHBEIN: I happen to know what Dr. Parran testified about concerning the building of hospitals. Now I know, and everybody knows, that in the new areas of industrial employment—

MR. KAISER *(interposing): You are getting away from my ship.*

DR. FISHBEIN: No, I am not. In new industrial areas such as those with which you are concerned, because obviously you didn't have all those people there before we got into the war, there are a total of about 5,000,000 people in the United States who have moved for an industrial job as the result of the war. Wherever they have gone we need hospitals, we need one at Valparaiso, Florida; we need them out in Richmond, probably; and we need them in Vancouver—but it is impossible to build a hospital using private funds or government funds now without obtaining a release on essential materials.

MR. KAISER: *We are doing it today, increasing our facilities.*

DR. FISHBEIN: I would say, Mr. Kaiser, that you are a very strong man and you get many things done that other men who are not quite so active do not get done.

MR. KAISER: *That is a beautiful out! But again how can we get the young man over to do the fighting unless he has something to sail in?*

DR. FISHBEIN: And how can you get him to sail unless you have a doctor with him?

MR. KAISER: *He therefore needs transportation and his health, and the health of the men that are building this transportation becomes fully as important as the men we send over.*

DR. FISHBEIN: Well, that is slightly debatable: whether or not a sailor or a marine who is fighting is more important than a shipbuilder, but I don't want to debate that.

MR. KAISER: *Please, I asked you a question and don't give the answer from me, I ask you to give it for yourself. Is it important to have transportation?* DR. FISHBEIN: It is of the utmost importance.

MR. KAISER: *And is it equally important to have the men there to build the transportation?* DR. FISHBEIN: It is important.

MR. KAISER: *Is it equally important?* DR. FISHBEIN: Equally important?

MR. KAISER: *Now the next question is: In that particular area where we didn't have that service, wouldn't you have created it?* DR. FISHBEIN: If I were there I would have had it.

MR. KAISER: *I really think you would do a remarkable work if you would immediately get busy, where it isn't being done today, and see that they are taken care of; and rather than defending it, correct it.* DR. FISHBEIN: Pardon me, I am not defending anything. I am trying to show you that your statements have been made, and also those of Dr. Garfield, without a knowledge of what has already been done and is being done. You are concerned only with your little problem.

MR. KAISER: *But it is only a model of them all, and I am now suggesting that you be concerned with them all and get this done.* DR. FISHBEIN: Suppose I told you that already we have reports from sixteen states in which there was said to be a shortage of doctors in certain areas that in ten of those states the shortages have been corrected. At Mobile, Alabama, the shortage has been corrected by furnishing doctors to meet the shortage.

Somebody has to make the decisions as to whether or not a young man under 37 years of age, in industry, who is a physician, is more important to that industry or more important to the armed forces. That decision cannot be made by the man who employs that young doctor in the industry. That decision must be made by an agency which is able to look at the matter in a completely unbiased way.

SENATOR PEPPER: *Would that agency be the armed service?* DR. FISHBEIN: No, by no means.

SENATOR PEPPER: *Aren't they the ones now making it?* DR. FISHBEIN: No, sir. The President's directive to the Procurement and Assignment Service and to the Office of Defense, Health and Welfare, which was Mr. McNutt's office at the time because that was before there was a War Manpower Commission, the President's directive to them said that they should have the consideration of an overall distribution of doctors to meet the needs of the armed forces, of industry and of the civilian population. And simultaneously with that there went an order to the Army Medical Department, the Navy Medical De-

partment, the United States Public Health Service and all other agencies employing physicians telling them that this agency had been established by order of the President for that job, and that they would submit their requirements to the Procurement and Assignment Service, which would aid them in meeting their needs.

SENATOR PEPPER: *You indicate, then, that the President intended that the Procurement and Assignment Service should act as the overall agency for the selection of medical personnel, but you don't mean to say that they have performed that function, do you?* DR. FISHBEIN: They have performed it within the law as it now stands, which puts the burden of ultimate decision regarding any man's service, when that man is under 45, on the local draft board.

SENATOR PEPPER: *Well then, the matter has not been decided by the Procurement and Assignment Service under the War Manpower Commission, it has been decided by the local service boards?* DR. FISHBEIN: The local draft boards. All matters of essentiality and the ultimate decision of forcing a young doctor into the Army have rested with the local draft boards.

SENATOR PEPPER: *So the President's directive has not been carried out, it has not been effective?* DR. FISHBEIN: It has been more effective in relationship to medicine than any similar effort in relationship to anything else.

SENATOR PEPPER: *Well, in spite of that fact you have some states where more than 200 per cent of the quotas of the doctors have been taken in, and in a state like South Carolina you have 170 per cent and in a state like Alabama 190 per cent who allowed that to happen?* DR. FISHBEIN: Well, it is still a free country—that is what permitted it to happen. The fact is that a man under 45 is under the control of the Selective Service board; a man over 45 is not under anybody's control in the United States.

SENATOR PEPPER: *(interposing): They were allowed to volunteer, then?* DR. FISHBEIN: Yes.

SENATOR PEPPER: *Was that decided by the Procurement and Assignment Service or by the armed forces accepting them?* DR. FISHBEIN: The armed forces obviously accepted them. But keep in mind your dates again! Keep in mind that the directive for the Procurement and Assignment Service did not begin until the end of October, 1941.

SENATOR PEPPER: *How many doctors had been taken in by that time?* DR. FISHBEIN: I will have to submit these individual figures to you; they are all here on the tables, and I will answer all your questions when I get the record.

SENATOR PEPPER: *Roughly how many had been taken in?* DR. FISHBEIN: Into the Army and Navy by October 1, 1941?

SENATOR PEPPER: *Yes.* DR. FISHBEIN: I would say roughly between 15,000 and 20,000, and 20,000 more came in between January, 1942 and September, 1942.

SENATOR PEPPER: *So that the shortage that the civilian population now experiences is due to the number that have gone in since that time, substantially?* DR. FISHBEIN: Very likely.

SENATOR PEPPER: *And now the question is as to whether we are going to allow that hit and miss system to continue to operate, or whether the President's directive is going to be made effective and some overall agency shall determine the needs of the Army and the needs of the civilian population?* DR. FISHBEIN: I would say that it operates effectively except for the unpredictable actions in certain areas of local draft boards. It operates effectively now: it didn't operate effectively before.

SENATOR PEPPER: *You mean that it operates effectively only to the degree that the local draft boards and the armed services allow it to operate?* DR. FISHBEIN: The armed services are giving complete coöperation—

SENATOR PEPPER *(interposing): They are not giving complete cooperation if the draft boards which represent the Army are doing something that is not a part of a comprehensive plan for the whole country.* DR. FISHBEIN: I would say that to the extent—

SENATOR PEPPER *(interposing): The truth of the matter is that we haven't had a plan so far; the President may have intended to set up one when he created the Procurement and Assignment Service, but to a few days ago, at least, there hasn't been a national plan for the Procurement and Distribution of doctors to assure public health to the civilian population?* DR. FISHBEIN: I don't think such a statement could be made with all the facts before you.

SENATOR PEPPER: *Where has it been operating, then?* DR. FISHBEIN: Suppose we had done what we did in World War I—

SENATOR PEPPER *(interposing): I am not asking you to suppose. Where has there been an overall authority that has been looking at this picture as a whole?* DR. FISHBEIN: You mean an authority to pick up doctors and move them around?

SENATOR PEPPER: *To say what doctors shall come in and what doctors shall stay out.* DR. FISHBEIN: The recommendation has been made in innumerable instances that certain doctors stay out, and the vast majority of Selective Service boards have respected those recommendations.

SENATOR PEPPER: *But they were pure recommendations and didn't have any authority?* DR. FISHBEIN: Only recommendations.

SENATOR PEPPER: *Now, Doctor, to get back to this group health insurance. You heard the testimony of Dr. Garfield that the head of Procurement and Assignment in the state of Washington raised objection to their medical facilities being extended to the members of the families of their employees. Are you prepared to state from personal knowledge that that is not the fact?* DR. FISHBEIN: No, sir; I would like to look it up, though.

SENATOR PEPPER: *All right, you have that privilege I am sure.*

DR. GARFIELD: *Incidentally that is not only on the prepayment plan, but they wouldn't let us take care of them as private patients.*

DR. FISHBEIN: I would like to ask you who stopped you, Doctor, from taking care of anybody? Did you try to take care of civilians and have them stop you?

DR. GARFIELD: *We were afraid to because they said—*

DR. FISHBEIN (interposing): Oh, now, Mr. Kaiser wouldn't be afraid.

DR. GARFIELD: *They stated that if we were to do that they would declare our doctors nonessential; they were cooperative up to that point.*

DR. FISHBEIN: Did you read that part where they said they would declare your doctors nonessential? DR. GARFIELD: No.

DR. FISHBEIN: You haven't that in writing? DR. GARFIELD: No.

SENATOR PEPPER: *Doctor, let me ask you this. The man who is reputed to have made that statement was head of the Procurement and Assignment for the state of Washington?* DR. GARFIELD: Yes, sir.

SENATOR PEPPER: *He had the power to make recommendations as to who was essential and who was nonessential as a doctor, did he not?* DR. GARFIELD: Yes, sir.

SENATOR PEPPER: *And that was the only governmental agency there was to make such recommendations, was it not?* DR. GARFIELD: Yes, sir.

SENATOR PEPPER: *And you assumed that if the doctors had violated the restraint that he had imposed, he would have had the power to have recommended that they be regarded as nonessential?* DR. GARFIELD: Yes, sir.

SENATOR PEPPER: *And that that recommendation would have been observed by the War Manpower authorities and by the Army Recruiting Service, emanating from Washington?* DR. GARFIELD: Yes, sir.

DR. FISHBEIN: I would say that no man has that authority; that he has never been given any such authority by any agency that I know anything about.

SENATOR PEPPER: *You mean that the Procurement and Assignment representatives in the States do not recommend as to whether a man is essential or nonessential?* DR. FISHBEIN: They have no authority to say to any man: Unless you do thus and so I will make you essential.

SENATOR PEPPER: *Do they have the authority to recommend to the Selective authorities those who are essential and those who are not essential?* DR. FISHBEIN: They recommend—

SENATOR PEPPER *(interposing): They do have that authority?* DR. FISHBEIN: They recommend under an established policy of the national Procurement and Assignment Service.

SENATOR PEPPER: *But they do have the power to go into a community and say "That man is nonessential" and "That man is essential" and to make that recommendation to the Selective Service authorities?* DR. FISHBEIN: They have that authority.

SENATOR PEPPER: *Now if that official chose to give furtherance to a policy of the American Medical Association against the particular kind of group health, and if he was, in furtherance of that desire, to designate a certain doctor as being nonessential, in all probability you say that the local draft board would take that man into the service if he was within the eligible age limit?* DR. FISHBEIN: I will have to come back first to the statement that the American Medical Association has such a policy—they have no such policy.

SENATOR PEPPER: *I am not asking you that. I ask if*

that Procurement and Assignment official were to make that recommendation to the Selective Service authorities that a particular doctor was nonessential, would the Selective Service authorities not in all probability take that man into the service? DR. FISHBEIN: That is correct.

SENATOR PEPPER: *Do you think it is wholesome public policy for the government to have as its representative in the selection of medical personnel a man who is in a position, at least, to further private interests by what he does?* DR. FISHBEIN: Well, that would involve, if a different policy was adopted, the destruction of the entire Selective Service system.

SENATOR PEPPER: *Would it be the Selective Service system or the system of the American Medical Association that would be disrupted?* DR. FISHBEIN: The American Medical Association has no system in relationship to these matters.

SENATOR PEPPER: *No. I am asking you would it not be appropriate for decisions of that character to be made by some official who has no personal or professional interest in the matter?* DR. FISHBEIN: The decision now rests with the Selective Service, which determines whether or not the man is or is not essential.

SENATOR PEPPER: *But the Selective Service, as you have said, in the selection of medical personnel relies on the recommendations of the Procurement and Assignment Service?* DR. FISHBEIN: I would say that in many instances they consider that that is authoritative, reliable evidence.

SENATOR PEPPER: *If they do—and you put into that place a representative of the American Medical Association—that man has the power, at least, by his action, to further a personal and professional interest, does he not?* DR. FISHBEIN: I would say that wherever you put a dishonest man or one who does not deal justly, you have trouble.

SENATOR PEPPER: *But, generally speaking, you try to disassociate a public official's functioning with his personal interest, do you not, or from his personal interest?* DR. FISHBEIN: I venture to say that practically every representative physician, whether or not a member of the American Medical Association, who today is charged with the duty of declaring that some men are essential and others are not essential, is carrying that out in a more high-minded and idealistic way than it possibly could be carried out by any other official.

MR. KAISER: *Senator Pepper, I think that the Doctor would be glad to know this: This is a conversation between Dr. Cutting and Dr. Fletcher, who is chairman of the State Procurement and Assignment Board of the state of California, and I will read just a portion:*

Dr. Fletcher said that, as for the program [speaking of our program] as a whole, it was not his place or jurisdiction to question the ethical end of it although he was against corporation medicine of which this is a type [this is right along the lines of your thought]. He thought that the California Physicians' Service and medical profession themselves should take care of it. If this group (which is our group) went into the coverage of the new housing projects going on in Richmond, he would be very much opposed to it.

DR. FISHBEIN: He has a right to be opposed to it.

MR. KAISER: *Now you maintain that he is not human and being opposed to it would therefore, even though he is not human, and being seriously opposed to it—we have frankly felt very much his attitude of opposition. I don't declare him dishonest, but he is not in favor of it and still he governs, through his recommendations, the men that we can or cannot have, and Dr. Garfield feels that he is doing him a great harm.*

DR. FISHBEIN: I will say again, and say it as simply as possible, that an attempt has been made, as nearly as I can judge it, from observing what has been done, an attempt has been made to administer this recommendation of who is or who is not essential in a certain area, with strict regard for the functions that the physicians were carrying out I could give you innumerable cases. It is without regard to any question of competition in practice, distribution of practice, among the people who remain, or any such matter.

But the policies of the Procurement and Assignment Service on a national scale have held that inasmuch as this is a war in which primarily the services of younger men are needed with troops in the field, that young men under 37 years of age who take full time positions in industry, in teaching, in research, with medical organizations or in any other way, and because they are holding such a position avoid being called into active service with the troops, that those young men must be subject to some higher agency than the industry itself. They have adopted a policy. When you could show that a young man—as in the case of Dr. Garfield, who is himself a young man—when you can show that a young man is your key man, that is all very well. But when you have a doctor under 37 years of age and you hold him because he is a specialist in nose and throat diseases, or you hold him because he is a specialist in urology, or you hold him because he is a specialist in obstetrics and a part of your organization, then obviously this higher agency which is looking toward the fact that we must win this war as our prime effort, and that we have to have young men to win the war, simply has to decide on a different level . . .

DR. LAMB *(interposing): There are already 40,000 doctors in the armed forces. If we maintain the present ratio, and there is to be a seven and a half million army we will have over 70,000 doctors in the armed forces, and if we have a 10,000,000 man army we shall have over 100,000 doctors in the armed forces. What would you say the proper ratio of doctors to the population, which was the absolute minimum, and how much further can we go in that direction?* . . .

DR. FISHBEIN: I would say that it is within the authority of the Army to change its ratios any time they find it is necessary or desirable.

DR. LAMB: *Would you have any opinion with respect to desirable ratios?*

DR. FISHBEIN: I would not have the impudence to say that. I would say to the Army, "The situation in civilian life is becoming critical and will you, if it is at all possible, economize on your use of doctors so as to leave the utmost possible for the civilian population?"

DR. LAMB: *How recently have you said that to the Army?*

DR. FISHBEIN: I must have said that in personal conversations or in writing many times.

DR. LAMB: *What was the first date at which you said that?*

DR. FISHBEIN: Well, I think the first date at which I said it was in 1940, in June, when we had a joint meeting with representatives of the Army and Navy and the United States Public Health Service, at which time we pointed out that we had just so many doctors and that sooner or later we would have to have definite quotas for each group to be served, the armed forces and the civilian population. . . .

DR. LAMB: *How would you revise them immediately?* DR. FISHBEIN: Already, wherever a shortage of physicians has been made clearly apparent—and we are conducting, incidentally, innumerable surveys, I have here the survey of the Public Health Service, of the Bureau of Economics, of the Procurement and Assignment Service, surveying all these areas—

DR. LAMB *(interposing): But your decisions with respect to these surveys have been made on the previous assumption that the ratio of 1 to 1,500 for the United States as a whole can be applied in some fashion to these areas of shortage?* DR. FISHBEIN: I believe, if you had asked Dr. Lahey that, he would have told you that that was certainly not the concept. Just yesterday the Committee on Allocations of the Procurement and Assignment Service determined that in any area where such a decision had to be made where there was a large city, and then a big rural area where you might get to 1 to 7,000, that obviously you would have to correct all your figures on that area on the basis that the large city was sucking in all the doctors and that special arrangements had to be made to meet those rural situations.

There is a physician in North Dakota who serves a rural area. He serves a radius of over 200 miles from his office. The only way he can serve that, obviously, is by motor car. If you today took that away, he couldn't serve any of the area except what was right next to him. The only was he can serve that area by motor car is to travel as rapidly as he can possibly travel, and to have snow-tires in winter, and to have enough gasoline to permit him to move. Unless you grant that doctor extra snow-tires in addition to the five tires that he is allowed, and unless you grant him enough gasoline to cover his area, you decrease his capacity by 90 per cent.

DR. LAMB: Yes, Doctor.

DR. FISHBEIN: Now there are federal agencies which have already forbidden him to have snow-tires: they said, "If you get two snow-tires you will have to give up two of your other tires." . . .

SENATOR PEPPER: *It is interesting that you, in your capacity as a paid representative of the American Medical Association, would exhibit the initiative that you—* DR. FISHBEIN (interposing): I have always exhibited the utmost initiative of which I am capable in matters affecting the public health.

SENATOR PEPPER: *I think the poor condition of public*

health in the United States probably proves you are correct in what you have said. DR. FISHBEIN: Now the next step, Senator Pepper, concerns a doctor who is a pediatrician in a small town in Illinois. He draws his pediatric practice from an area in that neighborhood of a little over a hundred miles. The farm women bring in their babies to this pediatrician. As far as I know, no method has been provided for permitting farm women to bring their babies in to where the doctor is. In other words, they also must exceed their total ration of gasoline in order to bring the baby to the doctor.

DR. WEBER: *Are pediatricians being taken into the Army?* DR. FISHBEIN: All classes of doctors are being taken into the Army. . . .

MR. KAISER: *The Doctor has intimated that he would emulate my technique in getting results by threatening publicity. I think that brings home a very important question, because if he really believes in that policy, possibly the medical profession or medical society must likewise believe in it, and that justifies the position that we have been holding. My feeling is that any one who, by threatening publicity, accomplishes anything both should be removed from the service of their country. I likewise feel that way both about myself and the medical association, if that is the policy they follow.*

DR. FISHBEIN: If we assume that the people of this country are the ones who run the country, the people must know. And the only way to get action is to let the people know. If you have an area in which there is a shortage of doctors and you want doctors, you have a right to let the people know that you are short of doctors. And then if you attempt various strong arm methods to accomplish things that are outside the law, and any newspaper finds that out, they have a right to let the public know.

SENATOR PEPPER: *If the American Medical Association finds a deficiency in doctors in the country, are you going to give publicity to that deficiency and use the full glare of the spotlight of publicity to remedy that condition?* DR. FISHBEIN: We are doing that all the time.

SENATOR PEPPER: *And if you should find that group insurance of a legitimate character would be a method of using more efficiently the medical talent and personnel of the country, are you going to use that same publicity to achieve that purpose?* DR. FISHBEIN: We not only have used the publicity but we have adopted the policy. There are thirteen state medical societies that have set up such plans, there are over three hundred counties that have set up prepayment plans for supplying medical service. We probably have failed in our publicity in not letting enough people know that the medical profession is itself working out these plans.

SENATOR PEPPER: *If you find instances in which members of the Procurement and Assignment staffs have used their public position and power to serve private end, are you going to give the spotlight of publicity to that?* DR. FISHBEIN: I would be the first to recommend removal. If it came to my personal knowledge that any doctor endeavored to coerce Dr. Garfield by saying to him, "You will either do this or you will be marked essential for military service." I would be the first to recommend that that man be removed from the position.

SENATOR PEPPER: *And if you found that there was an appreciable danger that that position was being abused to serve private ends, then you would recommend the reexamination of the policy of using such personnel in a government position?* DR. FISHBEIN: If I found that any system was capable of coercion in what is presumed to be a democracy, I would recommend a change in the system, because I have always been a believer in democracy.

SENATOR PEPPER: *Do you regard the American Medical Association as a perfect example of democracy in its functions?* DR. FISHBEIN: I would say that it is organized like the United States government, and it comes as near to functioning like a democracy as the government comes to functioning as a democracy.

SENATOR PEPPER: *Thank you very much, Doctor.*

NOTE. FOR NEWSPAPER REFERENCES TO THE "PEPPER HEARING," SEE "MILITARY CLIPPINGS," WHICH FOLLOW.

What Can War Manpower Commission Do?

Here are some questions and answers in connection with Paul V. McNutt's new powers as chairman of the War Manpower Commission:

Q. What is the WMC's overall function?

A. In the language of President Roosevelt's executive order of Saturday, "to promote the most effective mobilization and utilization of the national manpower and to eliminate so far as possible waste of manpower due to disruptive recruitment and undue migration of workers."

Q. Over what does WMC now have supreme authority?

A. Over all matters pertaining to procurement of manpower, military and civilian.

Q. Through what agencies will WMC exercise its new powers?

A. Chiefly through the Selective Service system and U. S. Employment Service, both of which WMC now operates.

Q. What persons are affected by the new grant of powers?

A. Everybody, man or woman. McNutt said he considered the entire population "a national pool" from which military, industrial and agricultural manpower needs will be filled. His guiding principle will be "to enable each man and woman to use his or her best abilities and skills where they will contribute most to the war effort."

Q. How will the new set-up affect procurement of men for the armed services?

A. Henceforth all services will obtain the bulk of their new manpower through Selective Service. Voluntary enlistments are terminated for men 18 to 38. The Navy may continue to recruit 17-year-olds and men 38 to 50. The Army does not accept men under 18 and, under a recent War Department ruling, will not take men 38 or older unless they are urgently needed because they possess certain special skills.

Q. How will the new induction rules affect applicants for commissions?

A. The Navy will continue to accept applications from men in the 18-38 category. It will not, however, continue to enlist officer candidates and permit them to continue in college. The War Department is still working out details of its new induction policies. The 38-year-old rule, however, will not affect volunteer officer candidates who have been accepted but not yet called. Such men will be inducted when the Army is ready for them, as in the past.

Q. Why are voluntary enlistments terminated?

A. Enlistments, McNutt said, have resulted "in the withdrawal of so many skilled workers as to threaten production of vital war materials." His aim is to allocate manpower between industry and the armed services "in an orderly process."

Q. Why has the War Department decided to discontinue accepting men 38 or older?

A. The Army found that men above that age, although passed by medical examiners as physically fit, cannot stand up under the rigors of army life.

Q. How will individual registrants be affected by the new orders?

A. The SSS and USES will review records of registrants to determine how their abilities may be most effectively used.

Announcing the Closing of the Medical Officer Recruiting Board

(COPY)

HQRS. MEDICAL OFFICER RECRUITING BOARD
Northern California, 450 Sutter St.
San Francisco, California.

No applications for commission can be accepted by this Board after December 15, 1942. Doctors who have not applied may do so up to and including that date.

All applications already made and now in process should be completed by December 15, 1942. This will be accomplished if requests from this Board to Doctors concerned receive prompt attention.

This Board, in closing, wishes to express its appreciation to the Medical and Dental professions for their coöperation.

(Signed) H. SCHWARTZMAN,
Major, Medical Corps,
President of the Board.

British Experience in Civil Defense

(COPY)

OFFICE OF CIVILIAN DEFENSE

Washington, D. C.

(Circular: Medical Series No. 20)

To: Regional Directors and Regional Medical Officers.
FROM: DR. GEORGE BAEHR, *Chief Medical Officer.*
SUBJECT: Lessons From British Experience in Civil Defense.
Special Distribution Instructions: To State and Local Councils.

Three years of British experience with air raids have significantly modified earlier concepts regarding the field casualty services. The following observations made on a recent inspection of emergency medical facilities in England and Scotland are forwarded for your information and for transmission through State Chiefs to local Chiefs of Emergency Medical Services.

1. *Heavy raids occur invariably at night;* heavier high-explosive bombs and land mines are now being employed, up to 2,000 kg., with much greater destructive effects. Incendiary bombs are used in much larger numbers, and fire is now the most serious hazard. Daylight raids are usually hit-and-run affairs in which solitary planes participate.

2. *In large cities* the field casualty services may handle 2,500 to 3,500 casualties during a night raid. All serious casualties are moved directly to hospitals, never to first-aid posts. Heavy raids are apt to be repeated on subsequent nights when the protective forces are exhausted.

3. *A large fleet of four-stretcher ambulances is essential for life saving.* Fourteen thousand ambulances were made in England and Scotland by purchasing used cars, stripping them, and then mounting a simple ambulance body on the chassis. London uses over 1,500 of such ambulances and 550 sitting-case cars. The use of tradesmen's trucks proved universally unsatisfactory; 3 out of 4 never arrived on the scene, and lives were lost due to the delay and confusion. Because of the large number of casualties to be transported in a few hours, no ambulances which carry less than 4 stretchers are employed. For the simultaneous evacuation of damaged hospitals, a fleet of 200 converted busses carrying 10 stretcher cases and 6 to 10 sitting cases are immediately available, and another 200 are obtainable within 2 hours.

4. *Casualty stations (British fixed first-aid posts) are necessary* at or near all hospitals and at places more than a mile from hospitals to care for minor casualties which do not require hospitalization. Many are now on a care-and-maintenance basis and are activated only during a raid. When functioning, the staff usually consists of one or two doctors, several nurses, and a variable number of aides and auxiliaries.

5. *In large cities casualty stations need not be more numerous than 1 per 25,000 inhabitants;* they should be located about a mile apart. There are less than 300 in the London area, with a population of about 10,000,000 and a land area more than twice that of Greater New York. In smaller, thinly settled communities, they are more numerous in relation to population, but the distances between them are proportionately greater than in metropolitan cities. Many of the minor casualties are moved to first-aid posts in sitting-case cars; some walk.

6. *First-aid parties (our stretcher teams) are not necessary,* are a waste of manpower, and are rapidly being eliminated. First aid at incidents is essentially a function of the rescue parties (our rescue teams), which extricate the casualties from under the débris of demolished buildings. All first-aid parties in England and Scotland are, therefore, being merged into the rescue parties. They include a leader, an assistant leader, and eight other members, and are entirely independent of the fire department. They are a life-saving service related to the medical services concerned in field casualty work.

7. *The experiences of Britain under air-raid conditions* have dispelled many preconceived notions concerning first aid. Almost all raids occur at night; the victims are crushed under the débris of demolished buildings and are either dead or severely injured; less than a third are slightly injured and can be cared for at casualty stations; all the severely injured must go to a hospital; victims are invariably covered with dust and dirt which hangs in the air for hours. The conditions under which the rescue workers encounter the injured beneath the structural débris, the darkness and the dust which always fill the air, the large proportion of dead and severely injured, and the urgent need for immediate hospitalization make it impossible to apply most peacetime concepts of first aid.

8. *Wounds are usually grossly contaminated* and need only be covered with a shell dressing until the casualty reaches the hospital. Hemorrhage is usually controllable with a pressure dressing. The tourniquet is rarely employed. Burns are covered only with sterile gauze until the casualty arrives at the hospital, Tannic-acid jelly as a first-aid dressing for burns has been discarded because of the dirt which invariably contaminates the burned surface, because the jelly deteriorates rapidly, and, lastly, because tannic acid ignites in the presence of phosphorus when applied to burns caused by the explosion of phosphorus-oil bombs.

9. *Traction splints are not used.* An exception is made if the casualty must be transported a long distance over country roads. Unlike Army field experience in the last war, the few miles of travel to a hospital over the paved roads of a city do not warrant the application of traction, especially as the darkness and the conditions of an air raid also make hurried application of the procedure difficult or impossible. All that can be done is to place the fractured extremity gently in alignment, bind it with triangular bandages to the uninjured leg or to an improvised splint, or apply a Thomas splint if one is on hand. Movement of the fragments can also be minimized by snug application of the blankets according to the Wanstead technique of blanketing and by the use of sand bags, which should always be carried in the ambulance.

10. *Shock is treated at the incident* by prompt administration of adequate doses of morphine (up to ½ grain for adults), coramine, proper blanketing, administration of fluids, and the use of hot-water bottles during transportation to the hospital. The use of plasma or blood transfusion is deferred until arrival at the hospital: it is ordinarily quite impossible in the darkness, dirt, and confusion at the incident.

11. *The presence of a physician at the incident is invaluable,* but more than one is unnecessary. In fact, one physician may cover several nearby incidents, leaving his nurse or one of the nursing auxiliaries of his emergency team at the incident while he moves temporarily from one to another in the immediate neighborhood.

12. *Even though a single night's casualties requiring hospitalization may total* one or two thousand, large hospitals rarely receive more than 50 to 100, the load being distributed as evenly as possible throughout the city.

13. *A large casualty receiving hospital is often related to one or more peripheral hospitals* in the suburbs or in a country district. There are now four base hospital beds for each casualty bed in the cities.

14. *Upon receipt at a local report and control center of a message from an air-raid warden that an incident and casualties have occurred, an "express party" is immediately dispatched to the scene.* An "express party" includes one rescue-first aid party, one ambulance, one sitting-case car, and one mobile medical unit (our mobile medical team). The latter consists of one physician, one nurse, and two auxiliaries. No other equipment and personnel of the emergency medical service is dispatched unless additional assistance is requested by the incident officer (usually a higher police official) or by the incident physician on the scene. In this manner useless movement is avoided and equipment and personnel of the community is carefully conserved.

Tales of Heroism

Medical Officer Tells of Men Under Fire

The cruiser San Francisco's medical men returned here yesterday to add their tales of heroism—of heroism under the combined hells of shellfire and pain, of sacrifice, and inspired duty.

"One Negro mess attendant," revealed Lieutenant Commander Edward S. Lowe, medical officer, "was standing in an exposed position during the battle.

"He deliberately got in the line of fire to protect a hospital corpsman taking care of a patient. He was killed."

The mess attendant was awarded the Navy Cross posthumously.

Commander Lowe, of Costa Mesa, California, himself awarded the Navy Cross for heroism under fire, declined to describe the reasons for his own award.

"Let me tell you about one of my corpsmen," he said. "He was shot in the leg and put out of action—but he cared for patients at his own request, in spite of his wounds.

"Another man, shot in the hand, took care of the wounded until he collapsed 36 hours later from exhaustion and his infected wounds."

Practically every dressing station was sprayed with Japanese metal during the battle of the Solomons, he declared.

"The fortitude of the wounded men brought to battle stations was wonderful. The morale was far above anything I ever expected."

Other officers and enlisted men praised Commander Lowe for his own personal gallantry and apparent fearlessness during the night of battle.

"If it hadn't been for the doc," one seaman declared, "there are a lot of us here today who otherwise would have been buried down there. Boy! he sure worked miracles by the carload!"

The Commander declared many of the wounded men survived as a result of the literally wholesale use of blood plasma and sulfa drugs for battle shock, burns and infections.—San Francisco *Chronicle*, December 12.

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4 Million Men Facing Draft Call in 1943

'Teen Age Induction Starts in January; Dependency Group Up in Few Months

Washington, Dec. 12—(INS.)—The War Manpower Commission announced tonight that a minimum of 350,000 men a month would be called into the armed services in 1943, and that married men would be inducted generally "before many months."

In a series of questions and answers on the draft, the Commission said that men with collateral dependents only, such as father, mother, etc., would be called first when it becomes necessary to tap the dependency groups.

Thereafter, men will be called from the dependency groups in the following order:

1—Married men with dependent wives only.

2—Married men with wife and children, or children only.

However, men not in essential industries or essential agriculture with dependents will be called ahead of men in essential industries with dependents. . . .

The commission said that the actual number of men to be called was a military secret, but that official estimates indicate a minimum of 4,200,000 in 1943, or 350,000 per month. These figures do not take into account replacements, the commission explained, so that the actual figure presumably will be higher.

This country probably will not, while the war lasts, reach a saturation point where it will need few additional soldiers, the commission said, since replacements will be required as long as the Nation is at war.

900,000 in 'Teens

Induction of 18 and 19 year olds will start in January, the agency pointed out. These boys will be called in the order of their age, beginning first with those who are nearly 20 years of age, and working down.

The number of 18 and 19 year olds available for early calls ranges from 600,000 to 900,000. They will not entirely fill the quotas for the early months of 1943.

Experience has shown, the commission said, that there are seventeen or more different classifications of married men for draft purposes, and local boards will use "their best judgment" in determining the precise order of their induction.

The commission pointed out, however, that the calling of married men with dependent children requires specific authorization by Maj. Gen. Lewis B. Hershey, director of selective service. No such order has been issued as yet.

New Class; 4-H

Although men may express a preference for the Army, Navy, etc., they will be assigned according to the needs of the various services and on the basis of individual skill and experience.

Men between the ages of 38 and 45, no longer to be inducted as a result of lowering the age limit to 38, will be placed in a new classification—4-H. They could be available for armed service if the President should rescind his order.

No effort will be made to force them into essential industries, but the commission hopes most of them will find jobs in war industries.

Local boards have been instructed to reclassify men with collateral dependents only, and married men without children, into Class 1-A, thus making them available for call.—San Francisco *Examiner*, December 13.

Military Clippings—Some news items of a military nature from the daily press follow:

Country Club in Alameda County Turned Into Navy Hospital

Heroes of Pacific Battles Aided to Recovery by Peaceful Life Among Hills of East Bay

The peacetime playland that was the Oak Knoll Country Club has become a wartime haven for the wounded of the South Pacific.

Sailors and marines, officers and men who have looked on the face of the enemy and felt the fury, loaf in the sun, now, where Sunday golfers used to curse the sand traps.

Sixty new buildings, sheltered in a fold of the eastbay hills where the country club's greens and fairways used to be, have been completed at the site since spring. Commissioned in July, the hospital, one of three Naval hospitals in the bay area, now houses between 800 and 900 patients. It will accommodate slightly more than 1,200 when completed. Other Naval hospitals are at Mare Island and Treasure Island.

Long Convalescence

Because only completely well men can take part in active duty, military hospitals accommodate their patients through long convalescent periods. Almost two-thirds of the Oak Knoll patients are able to be up and about by now—"and they enjoy the hills, the view, and watching the new lawns come up," their doctors explained.

For staff, the hospital has some fifty medical men, each a specialist, besides, Navy nurses and members of the Navy medical corps.

Heroic Surgeon

Matching the heroes of the present war—dozens of them in any direction, at Oak Knoll—is the medical officer in command, Capt. Frederick R. Hook, who was a young surgeon when he joined the Navy in April, 1917, and came home from Europe in 1919 with a Navy Cross, a Distinguished Service Cross, a Croix de Guerre, assorted citations, and the right to wear the Fourragere the French Government awarded to the Fifth United States Marines.

The hospital has elaborate equipment—operating rooms capable of taking care of a dozen or so cases in a morning; elaborate x-ray photographic and treatment units; a man-size fluoroscope; therapy equipment; light, airy wards with sunrooms; laboratories and a pharmacy, and mess halls for the patients who are almost well. The old clubhouse has become a recreation center, with a library, a soda fountain, a barber shop and the like.

Heroes Recovering

A few local casualties—men stationed in the Bay area who had arguments with motorcycles, or were hurt in other accidents, are under treatment at Oak Knoll. But most of the patients are already on the way to recovery, after preliminary treatment at advanced base hospitals, by the time they reach the East Bay institution.

In the last group are men like the highly indestructible Eugene Moore—the marine who didn't realize a mob of Japs had "killed" him at Guadalcanal—and Carl Greer, fireman, first class, aboard the Yorktown, who jumped seventy feet into the sea with a wounded comrade in his arms, and acquired two broken legs and a ruptured diaphragm.

Both Moore and Greer are getting well. They'll be out admiring the new lawns, pretty soon.—San Francisco *Examiner*, November 14.

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Physician Allocation Not Urged by Health Service

Washington, Nov. 4—(UP.)—Surgeon-General Thomas Parran of the United States Public Health Service, says he is not in favor now of compulsory allocation of physicians.

Parran testified before a Senate education and labor subcommittee which is investigating methods to protect the health of the country by possible enactment of a national service act for the medical profession.

"I am not prepared at this time to recommend the allocation of doctors by a national service act," Parran said. "We may need to come to that on the medical front in order to alleviate the serious depletion of doctors in many areas, but I would not endorse any compulsory legislation affecting the medical profession at this time."

Heatedly disagreeing with Parran was Dr. Paul de Kruif, author of medical books written for laymen, who denounced "white-wash" methods of the American Medical Association and recommended federal supervision over allocation of all members of the medical profession.—Alameda *Times-Star*, November 4.

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Army, Navy Get Doctor Quotas for Rest of 1942: A.M.A. Conference of State Association Secretaries and Editors

The Army and Navy have obtained all the medical men they have requisitioned up to January 1, Dr. Frank H. Lahey, chairman of the board of procurement and assignment service for physicians, dentists and veterinarians, said here today. But this, he indicated, was achieved with the aid of states which exceeded their quotas and made up for the shortages of Illinois and four other states.

Dr. Lahey made his report at the annual conference of secretaries and editors of state medical associations at the headquarters of the American Medical Association.

The other states that have not met their quotas, he said, were California, Connecticut, Massachusetts and New York. He explained that the plans for allocating doctors provide that there shall be one doctor for each 1,500 civilians.

No Additional Drawing

"There will not be any additional drawing for the armed services that have exceeded their quotas till the others have been brought up," said Dr. Lahey.

Dr. Lahey added for the encouragement of civilians that the ratio of one doctor to 1,500 civilians, which will be preserved as long as possible, is relatively generous by comparison with the ratio of other nations. In England the present ratio is one to 2,700 and in Germany, one to 12,000.

"In the United States before the war," he said, "in some cases, in congested cities, there was one doctor to 500 patients, and in some rural areas, as few as one to 2,500.

Divided Into Two Classes

"The medical population of America has been divided into the doctors essential in the civilian community and those available for the armed forces. Thus far 218 physicians have been relocated in 154 communities in 29 different states."

All needs have been met by the voluntary system, and Col. Fred W. Rankin, president of the American Medical Association and a reserve medical officer, expressed the hope that there would be no drafting of physicians for professional purposes "until all elements of the population are placed under draft regulations."

Rear Adm. Ross T. McIntire, surgeon general of the U. S. Navy, urged that planning begin now for low-cost medical care after the war, "when money will be scarce."—Chicago *Daily News*, November 20.

* * *

Manpower Problem

9,700,000 Men in the Services by End of 1943

Washington, Nov. 10—(AP.)—President Roosevelt, asserting that something must be done about the manpower situation in the next two or three weeks, disclosed today that the fighting forces will number about 9,700,000 men by the end of 1943.

Between now and that time, he said at a press conference, the Nation must find four or five million more men—the best young manhood—for the armed services. Simultaneously, he added, it must find men to take care of the food problem and industrial production, which is still short of its peak.

His statement came in response to a question whether he favored transferring the selective service system to the War Manpower Commission, as recommended by a management-labor policy committee of WMC. It was, he said, all part of the manpower question. He has been devoting a lot of time to that problem. There was no immediate emergency, but something must be done in two or three weeks.

As for the armed forces, there were now, he said, about 4,500,000 in the Army, which must be increased to about 7,500,000 by January 1, 1944. Meanwhile, the Navy's present 1,000,000 must grow to 1,500,000, and the Marine Corps and Coast Guard must be increased from 400,000 to 700,000.

Getting down to actual numbers for the combat forces, the President said tens of thousands of additional men were being added each month for the fighting forces and to hold bases already acquired.

Going along on an orderly basis, he said it was planned to keep this increase rising until a goal of about 7,500,000 is reached. Mr. Roosevelt said he hoped that would be enough but that at present the Government could not look beyond January 1, 1944.

In increasing the Army, the President said it must be made sure that the men are well equipped and have the necessary munitions.

This meant, he added, that large numbers of people must be had from civilian life to make those supplies and equipment to keep pace with the orderly increase in the Army.

The same held true for the Navy and other fighting services, he said.—San Francisco *Chronicle*, November 13.

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18-Year-Olds Register for Army Dec. 11-31

Washington, Nov. 18—(INS.)—President Roosevelt today ordered that all youths who have become 18 years of age since last June 30 register for military service during the three weeks from December 11 to December 31.

It is officially estimated that there are 600,000 youths in this age bracket.

At the same time, the President in a proclamation

directed that during the rest of the war young men who were born after January 1, 1925, shall register for military service as soon as they reach their eighteenth birthday.

Three Registrations

Youths born during July and August will register during the week of December 11. Those born in September or October will register during the week beginning Friday, December 18. Those born in November or December will register in the week beginning Saturday, December 26.

U. S. Employees Liable

Selective service headquarters prepared to register the youths coincident with presidential orders cancelling draft deferments of government employees.

A "lot of men," not now in the draft because they are working at desks in crowded government offices in Washington and scores of other cities, faced induction into the army as the result of a White House directive.

The men—and it was estimated that there were enough to make up an entire division—saw induction near after President Roosevelt instructed the heads of all government agencies to cease asking military deferments for any of their employees.

New Draft Rules

At the same time, Maj.-Gen. Lewis B. Hershey, national draft director, instructed local boards to carry out the "teen-age" draft act by the following actions:

1. Deferment of farm workers, of all ages 18 to 45, who are necessary to and regularly engaged in work in war-essential agriculture.
2. Distribution of questionnaires to 18 and 19-year-old registrants, who will begin to be inducted as their order numbers are reached.
3. Deferment of high school students in the 18 and 19-year groups, if the students request it and if they are in the last half of the autumn-to-spring school years.
4. Deferment of all men who registered before age 45 who have passed their forty-fifth birthday since, unless they file their written consent to induction into the armed forces.

Two new classes, II-C and III-C, were announced for deferred farm workers. Those without dependent wives, children or other grounds for dependency deferment will go in II-C, those with dependency to III-C.

Month Before Induction

Selective service officials estimated that it would be at least a month before the first 18 and 19-year-olds are inducted. Questionnaires have to be mailed out, returned and classified. Ten days are allotted for returning the questionnaires.

Men who were 18 years old on last June 30 already are registered and will be inducted in the order of their birthdays. Another registration will be held in December for those who have reached the age of 18 since last June 30.

After January 1, selective service officials said, those who become 18 years old will register at local boards on their birthdays.

One spokesman estimated that there were 700,000 men available for the draft in the group who were 18 years old on last June 30, while approximately 1,000,000 men become 18 each year.—Wichita Kansas *Beacon*, November 19.

* * *

Manpower: We'll Have to Supply a 62 Million Fighting and Working Force by End of '43

America stands today in manpower problems where Germany stood five years ago, the Office of War Information reported yesterday, in announcing the United States faces a need of supplying a working and fighting force of 62,500,000 by December, 1943.

"Between June, 1940, and June, 1942, the number of persons in civilian employment and the armed forces increased from 48.1 millions to 57.1 millions," the statement said. "Of these, 5.8 millions came from the ranks of the unemployed, and most of the remainder represented the natural increase in the working force.

"To get an additional 5.4 million, the Nation must dip into its potential labor reserve of 31.9 millions—the 2,000,000 farm operators working submarginal land and producing only 3 per cent of the commercial farm crop, the 4.4 million nonfarm housewives under 45 with no children under 16, the 9.1 million nonfarm housewives over 45, and the 6.9 million students between the ages of 14 and 17.

"Germany exhausted such reserves years ago. Japan has been facing a critical labor shortage for two years. Japan drew her army from the agricultural areas and did not, therefore, disrupt her industrial functioning. Japanese law permits children over 12 to work provided they have completed their compulsory education."

The statement said the problem facing the United States is to make a full utilization of local labor through training programs and advancement of minorities before calling upon outside labor and to prevent employers from luring workers from other and equally vital war jobs.—San Francisco *Chronicle*, November 9.

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Medical Science Will Protect American Troops in Africa

Richmond, Va., Nov. 10—(AP.)—Medical science has a "third front" established in Africa to protect our fighting forces there against a foe as dangerous as the Axis—tropical disease—Dr. Joseph S. D'Antoni, vice-president of the American Society of Tropical Medicine, said today.

"The men will be well protected; every precaution known to medical science has been taken," declared the Tulane University doctor in an interview at the opening of a wartime meeting of the Southern Medical Association with which his society is convening jointly.

Doctors Trained

"Long before our African campaign started," he said, "our Government had studies made of possible health hazards there and in other countries where our troops might be engaged, and trained doctors and sanitary engineers are prepared to cope with the situation."

Asserting that malaria and two forms of dysentery were the most important tropical problems, he said, "if our offensive action in Africa takes our troops into malarious country, they will be provided with anti-malaria drugs. There is a shortage of quinine, but we have another, atabrine, which is prepared in New York.

"Again, with regard to the dysenteries which result from tainted drinking water, sanitary engineers are prepared to rule various water supply sources 'out of bounds.'"

Under Control

He said vaccines were also available as protection against certain other tropical diseases which he was not at liberty to list.

The British have tropical diseases under control in Libya, said the doctor, adding:

"We can go back still further. Private communications received in this country report that during Italy's campaign in Ethiopia there was not a single fatal case of malaria due to malaria prophylactic measures directed by Dr. Castellani, medical director of the Italian Army.

"That was the first colonial war in the history of the world where tropical disease didn't produce more deaths than actual combat. And since that time there has been an increase in our knowledge of tropical diseases."—Oakland *Tribune*, November 10.

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Ships' Doctors Unsung Heroes of U. S. Fleet

Sea Surgeons Think Nothing of Performing Major Operation Aboard Bouncing Warship

Aboard a Cruiser With U. S. Fleet, Solomons Area—(Correspondence of the Associated Press).—"Come below and watch us do an appendectomy," said the young medical officer.

It was 8 p. m. on a peaceful, moonlit night in the Solomons waters. It was not a peaceful night, however, to a young sailor who tossed in a bunk below.

In the operating room, two surgeons, several pharmacists' mates, and this correspondent put on white gowns and masks.

Surely, steadily, the two surgeons went at their task. They bracked their feet, for there was a slight roll to the cruiser. We could hear the waves slap against the side of the ship.

Local Anesthetic

The sailor had wanted a local anesthetic and he got it. In the tropic heat, perspiration ran down the patient's face and down the faces of all of us standing around the operating table. One man was kept busy wiping faces with a cool rag.

This surgery at sea is routine to the doctors of the fleet—men who fight to save lives, not to take them. They think nothing of operations in a bounding warship.

It was found that the young sailor's appendix would have ruptured by morning. Now he is making fast recovery, and soon he will be ready for another crack at the Japs.

These fleet doctors—many of whom gave up lucrative practices to join the Navy—have saved hundreds of lives since war began. This cruiser has taken aboard many injured survivors.

3 Days Without Sleep

On one occasion, a doctor worked on injured men for

three days and three nights without sleep—and only occasional cups of coffee.

Many of the survivors were more dead than alive when they were brought aboard and placed on the decks, in the hangars and sick bay. Some were injured, mangled and burned so badly that tough old sailors turned their heads away to avoid the sight.

But not a man died on this cruiser. All recovered, and the great majority are out again with the fleet.

"They were the bravest, finest patients a man could ask for," this doctor said. "They were typical of our American sailors."

"As far as glory goes, I don't think a man could want more glory than to see those men get well and return to their guns—able to use their arms and legs and muscles again!"

Always on Call

A physician is the closest thing to a mother that the sailors have aboard a warship. He's on call twenty-four hours a day to administer treatment, give advice and listen to complaints.

Except for an occasional appentectomy and colds, there is little sickness aboard the average United States warship.

"Our job is not so much to treat them, as to keep them well and in fighting shape," said the physician.

"Altogether, they are the healthiest bunch of men I've ever seen. Although they live in a space more crowded than the worst tenement district, the excellent sanitation of the ship and the personal cleanliness of the men tend to keep them healthy. Then, of course, they live a rugged outdoor life and they get lots of exercise and a well balanced diet."

Come in Threes

It was midnight when we decided to "hit our sacks," as they speak in the Navy of going to bed.

Just then an orderly approached and announced that another sailor had come to the sick bay with a "stomach ache."

"Probably another appendix," the doctor said over his shoulder as he started away. "They always come in threes. See you in the morning."—San Francisco *Examiner*, November 13.

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Dr. Fishbein Defends A.M.A.

Washington, Nov. 6—(AP.)—Dr. Morris Fishbein, editor of the American Medical Association's Journal, challenged charges of A.M.A. selfishness in the drafting of doctors for the armed services before a senate committee today.

At times, Dr. Fishbein engaged in spirited debate with Henry J. Kaiser, the West Coast shipbuilder, as to the deferment of doctors for the care of industrial workers.

Referring to suggestions for compulsory assignment of doctors to areas of few physicians, Dr. Fishbein said he opposed "certain proposals to meet the needs that are close to totalitarianism."

He declared that doctors of the A.M.A. in charge of the government's procurement and assignment service for the armed forces have carried out their duties "in a more highminded way than they could be carried out by any other officials."

A.M.A. Has Similar Service

He asserted that the A.M.A. itself had worked out plans to prepaid medical care and that 13 state medical societies had set up plans for this form of health insurance. This was in answer to a statement by Dr. Sidney Garfield, Kaiser's medical director, that Washington State Medical Society officials had threatened, in effect, to draft his company doctors if they served the families of workers on a prepaid basis.

"Have you got that in writing?" Dr. Fishbein asked.

"They wouldn't dare put that in writing," Kaiser replied.

Dr. Garfield told of conditions in Vancouver in relating why the company medical program included families of workers.

Under the medical program, the doctor said each worker desiring to participate pays 50 cents a week to get company medical care.

"Orally," Dr. Garfield told a senate labor subcommittee, "we were told that 'If you take care of the families, we will declare that your doctors are nonessential.'"

Washington State Group Blamed

Dr. Garfield said this "threat" was made by the Washington state medical society's executive committee. Under questioning by Senator Pepper (D.-Fla.), Dr. Garfield said the chairman of that committee also was state chairman of the government's service for the procurement and assignment of doctors for the armed forces.

Senator Pepper asked if "the same man who is supposed to represent the United States in the procurement of doctors for the army and navy" is taking "advantage of his position as a public official to promote the private interests of the medical association."

"That's it," Dr. Garfield said.

"So that public policy emanates primarily from a private source," Senator Pepper commented.

At another point, Dr. Garfield said the procurement and assignment service "represents the views of the American Medical Association."

'Army Has Enough Doctors'

"I don't want this interpreted as an attack on the medical society," Dr. Garfield said, "but it is hindering us from doing a necessary job."

Kaiser pointed out that the army has 40,000 doctors for 4,000,000 men, or one per hundred, while in his plant the "army of supply" had one doctor to every 2,000 men. —Pomona *Progress-Bulletin*, November 6.

* * *

Medical Journal Hits Kaiser Setup

Chicago, Nov. 10—(UP.)—The Journal of the American Medical Association charged in an editorial today that some physicians and industrialists, including Shipbuilder Henry J. Kaiser, desire to maintain intact their own staffs of doctors "regardless of the needs of the armed forces."

The Journal defended the work of the procurement and assignment service for physicians, dentists and veterinarians in allocating medical personnel for military, industrial and civilian needs and accused Sen. Claude Pepper (D), Fla., of calling before a senate hearing only such physicians and others who were dissatisfied with the procurement and assignment service.

Pepper, charged by the Journal with conducting a "one-man inquisition," heads the senate committee on education and labor now conducting hearings on the medical personnel situation.

"One of the chief facets thus far obvious (in the senate hearing) is the desire of some industrial leaders and of the full-time staffs of physicians which they employ to maintain their individual empires without disturbance regardless of the needs of the armed forces for physicians."

Scores Setup

"They believe apparently that individual physicians should be taken by the armed forces before clinics, private hospital staffs, industrial organizations or similar groups are in any way disturbed."

"Prime movers in an assault upon the procurement and assignment service" for its allocation of doctors, the editorial said, are Drs. Paul de Kruif and Michael M. Davis, Kaiser and the head of his medical services, Dr. Sidney Garfield.

"Already," the editorial said, "evidence has been submitted that the services established by . . . Kaiser, under the direction of . . . Garfield, and endeavoring to hold from the armed forces even the opportunity to determine for themselves whether or not the considerable number of young men employed on salaries by this industrial organization are fit and available for military service."

Blow to Morale

The Journal said a doctor's fitness for the military must not be left to his employers and should be determined by local draft boards upon advice from the procurement and assignment service.

"The performance displayed in Senator Pepper's hearings," the editorial concluded, "is not likely to improve the morale of American medicine at the very time when it should be at its highest in the service of the war effort." —Oakland *Post-Enquirer*, November 10.

* * *

Doctor Draft Challenged By A.M.A. Journal

Procurement Census Made in 1940, Publication Points Out; Recruiting of Medics Hit

Chicago, Nov. 3—(INS.)—The Journal of the American Medical Association today challenged a recommendation by a Senate subcommittee on manpower that an over-all civilian authority should be established to enroll physicians for the armed services.

The committee, headed by Senator Claude Pepper, urged that a study be made to determine the number of doctors needed for civilian communities and that a census of medical men be taken.

"Had Senator Pepper's committee made inquiry, it would have discovered that the inventories proposed were made by the American Medical Association in 1940, and by the procurement and assignment service in 1941, and that studies are made week by week of the distribution of physicians in civilian communities," the Journal said.

"The procurement and assignment service was created by the President of the United States and charged with consideration of the task of meeting the needs for physicians of the armed forces, industry and civilian population.

"It has approached the problem scientifically, with accurate inventories of physicians available and needed with due regard for the health of all the United States.

"Actually, what has been done might . . . well serve as a model for the other activities of the War Manpower Commission."

The publication also scored a committee recommendation that no recruiting of doctors for the military forces be permitted until the civilian authority was created. The Journal said:

"The least that the Nation can do for those who offer their lives in combat is to provide them with the utmost that medicine can offer for the alleviation of the wounded and the prevention of unnecessary death."—Los Angeles *Examiner,* November 4.

* * *

Medical Journal Denounces Kaiser and Senator Pepper

Chicago, Nov. 10.—The Journal of the American Medical Association charged in an editorial today that some physicians and industrialists, including Shipbuilder Henry J. Kaiser, desire to maintain intact their own staffs of doctors "regardless of the needs of the armed forces."

The Journal defended the work of the procurement and assignment service for physicians, dentists and veterinarians in allocating medical personnel for military, industrial and civilian needs and accused Senator Claude Pepper (D., Fla.) of calling before a Senate hearing only such physicians and others who were dissatisfied with the procurement and assignment service.

Senator Pepper, charged by the Journal with conducting a "one-man inquisition," heads the Senate committee on education and labor now conducting hearings on the medical personnel situation.

"Prime movers in an assault upon the procurement and assignment service" for its allocation of doctors, the editorial said, are Drs. Paul de Kruif and Michael M. Davis, Mr. Kaiser and the head of his medical services, Dr. Sidney Garfield.

"Already," the editorial said, "evidence has been submitted that the services established by . . . Kaiser, under the direction of . . . Garfield, are endeavoring to hold from the armed forces even the opportunity to determine for themselves whether or not the considerable number of young men employed on salaries by this industrial organization are fit and available for military service."

The Journal said a doctor's fitness for the military must not be left to his employers and should be determined by local draft boards upon advice from the procurement and assignment service.

"The performance displayed in Senator Pepper's hearings," the editorial concluded, "is not likely to improve the morale of American medicine at the very time when it should be at its highest in the service of the war effort."—San Francisco *News,* November 10.

* * *

Kaiser Asks Probe of Dr. Fishbein

New York, Nov. 14—(INS.)—Henry J. Kaiser, industrial wizard, today took time out from breaking shipbuilding records to challenge the integrity of Dr. Morris Fishbein, secretary of the American Medical Association.

Demanding that members of the organization investigate the medical executive because of an editorial in the current issue of the Association's journal, Kaiser asked, "If they find Dr. Fishbein in his attack on my motives to be dishonest or unworthy to represent their ideals they should immediately request his resignation."

Kaiser's challenge was based on the editorial charge in the Journal that he and other industrialists "desired to maintain their individual empires without disturbances, regardless of the need of the armed forces for physicians."

The question of conscription status of company doctors was thrashed out at the November 6 Senate Committee hearing in which Dr. Sidney Garfield, Kaiser's medical chief, asserted that A.M.A. members in charge of procurement for the armed services were threatening to draft Kaiser's company doctors unless they ceased group health activities.—Stockton *Record,* November 14.

* * *

Deferment of 3-A's Offered For War Work

Men With Dependents Given New Inducement to Leave Nonessential Employment

Washington, Nov. 5.—(AP.)—The selective service system is seeking to induce large numbers of men with dependents to shift from nonessential work to war-supporting occupations by offering them the prospect of longer deferment from the draft. . . . —San Francisco *Examiner,* November 6.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Fifth Annual Congress on Industrial Health

The fifth Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, will be held Monday, Tuesday and Wednesday, January 11-13, 1943, at the Palmer House in Chicago. These meetings are open to physicians and others interested in industrial health. There is no registration fee. The preliminary program is as follows:

Monday, January 11—Opening Session, 9:45 A.M.

Papers

Report of the Council on Industrial Health.
The Physician and Industrial Mobilization.
Preventive Medicine in Industry.
Employee-Management Coöperation for Industrial Health.
Procurement and Training of Professional Personnel for Industrial Health Service.
Ocular Signs of Industrial Poisoning.

Program by Days: Major Divisions

COMMON INFECTIONS IN INDUSTRY

(Joint Presentation by the Council on Pharmacy and Chemistry and the Council on Industrial Health, American Medical Association.)

Monday—Evening Session, 6:30 o'clock

STATE SOCIETIES' DINNER AND ROUND TABLE

An informal dinner and round table discussion, intended primarily for the personnel of committees on industrial health in state and county medical societies, will be held. Subjects for discussion will be:

Local Organization for Industrial Health Services.
Recent Experiences in Postgraduate Industrial Medical Education.

Tuesday, January 12—Morning Session, 9 o'clock

Industrial Physical Examinations: Report of the Committee on Physical Examinations of the Council on Industrial Health, American Medical Association.

HEALTH PROBLEMS ASSOCIATED WITH THE CHANGING CHARACTER OF THE WORK FORCE

Tuesday—Afternoon Session, 2 o'clock

INDUSTRIAL MEDICAL PRACTICE AND THE EMERGENCY

Streamlining Industrial Medical Service
How to Get Along with Less Help.

Tuesday, January 12—Morning Session, 9:30 o'clock

SYMPOSIUM ON MEDICAL RELATIONS IN WORKMEN'S COMPENSATION

(Joint Presentation by the Bureau of Legal Medicine and Legislation and the Council on Industrial Health, American Medical Association.)

Tuesday—Afternoon Session, 2 o'clock

SYMPOSIUM ON REHABILITATION

(Jointly Sponsored by the Council on Physical Therapy and the Council on Industrial Health, American Medical Association.)

Wednesday, January 13—Morning Session, 10 o'clock

SYMPOSIUM ON NUTRITION IN INDUSTRY

(Jointly Sponsored by the Council on Foods and Nutri-

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

tion and the Council on Industrial Health, American Medical Association.)

Wednesday—Afternoon Session, 2:30 o'clock

A Conference on Industrial Health will be presented under the auspices of the Chicago Medical Society and the Illinois Manufacturers' Association, together with many additional local and state collaborating agencies.

Ninth Annual Postgraduate Assembly: C.M.E.

The Alumni Association of the College of Medical Evangelists, in Paulson Hall of White Memorial Hospital in Los Angeles, on Sunday, December 6, 1942, presented its Ninth Annual Postgraduate Course. Program follows:

Morning Session

9:00 a.m.—"Combined Chemo Therapy and Fever Therapy in Treatment of Syphilis."
H. Worley Kendall, M. D., Associate Director of Kettering Institute for Medical Research, Miami Valley Hospital, Dayton, Ohio. (Dr. Kendall's paper will be read by Fred B. Moor, M. D., Professor of Pharmacology and Therapeutics, College of Medical Evangelists School of Medicine, Los Angeles, Calif.)

9:30 a.m.—"Primary Coccidioidomycosis."
William A. Winn, M. D., Medical Director, Tulare-Kings Counties Tuberculosis Hospital, Springville, Calif.

10:00 a.m.—"The Causes of Hypertension."
Maj. William Dock (MC), Professor of Pathology, Cornell University Medical College, New York, N. Y. (On military leave.)

10:30 a.m.—"Management of Chemical Injuries of the Eye (Including War Gases)."
Harold F. Whalman, M. D., Clinical Professor of Ophthalmology, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

Recess

11:15 a.m.—"Principles of Differential Diagnosis."
Julius Bauer, M. D., Clinical Professor of Medicine, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

11:45 a.m.—"Recent Advances in the Treatment of Pelvic Inflammatory Disease."
George E. Judd, M. D., Assistant Clinical Professor of Gynecology and Obstetrics, University of Southern California School of Medicine, Los Angeles, Calif.

12:15 p.m.—"The Physician and the Social Implications of the War."
Walter H. Brown, M. D., Professor of Public Health, University of California School of Medicine, San Francisco, Calif.

Afternoon Session

2:30 p.m.—"Differential Diagnosis of Chronic Sinusitis and Chronic Allergy."
Ben R. Dysart, M. D., Instructor in Surgery (Otolaryngology), University of Southern California School of Medicine, Los Angeles, Calif.

3:00 p.m.—"Office Management of the Diabetic Patient."
Howard F. West, M. D., Clinical Professor of Medicine, University of Southern California School of Medicine, Los Angeles, Calif.

3:30 p.m.—"Lessons in Fracture Surgery from Recent War Casualties."
Comdr. Rudolph Joldersma (MC), Chief of Orthopedic Service, U. S. Naval Hospital, San Diego, Calif.

Recess

4:15 p.m.—"Manipulative Therapy for Back Injuries."
Horace C. Pitkin, M. D., Consulting Orthopedic Surgeon, Stanislaus County and St. Francis Hospitals, San Francisco, Calif.

4:45 p.m.—"Intravenous Urography."
Jay J. Crane, M. D., Associate Clinical Professor of Surgery (Urology), University of Southern California School of Medicine, Los Angeles, Calif.

5:15 p.m.—"Hypothyroidism."
E. Kost Shelton, M. D., Associate Professor of Medicine, University of Southern California School of Medicine, Los Angeles, Calif.

Evening Session

7:00 p.m.—"Physical in Contrast to Psychic Treatment of Certain 'Psychiatric' Disorders."
Johannes M. Nielson, M. D., Associate Clinical Professor of Neurology and Psychiatry, University of Southern California School of Medicine, Los Angeles, Calif.

7:30 p.m.—"Practical Aspects of the Diagnosis of Breast Tumors."
Isaac Y. Olch, M. D., Assistant Clinical Professor of Surgery, University of Southern California School of Medicine, Los Angeles, Calif.

8:00 p.m.—"Determining Factors in Prognosis and Treatment of Mammary Carcinoma."
Ian J. Macdonald, M. D., Instructor in Surgery, University of Southern California School of Medicine, Los Angeles, Calif.

8:30 p.m.—"Certain Aspects of Sulfonamide Therapy."
Frederick J. Moore, M. D., Instructor in Bacteriology, University of Southern California School of Medicine, Los Angeles, Calif.

Registration Fee $2.00.

No registration fee will be required of students, interns or residents.

COMMITTEE ON MEDICAL EDUCATION

Peril to Supply of Doctors Seen

Unless provision is made to assure a minimum of two years' premedical education," only women and the physically unfit" will be able to enter medical schools next year. Brig. Gen. Charles C. Hillman, surgeon general of the army, on November 20th, told army, navy, and civilian doctors attending the annual conference of Secretaries and Editors of Constituent State Medical Associations at 535 North Dearborn Street.

Gen. Hillman explained the lowering of the draft age to 18 is taking men who normally would enroll in medical courses next year. He expressed hope that plans will be made to assure a continuous supply of new physicians for essential industries and civilian communities.

Despite this future threat to medicine, speakers agreed the medical profession has supplied the armed forces with all the doctors required so far, and there still are enough left to assure civilians adequate medical attention. There is no likelihood of a shortage of doctors for the present, they said.

Dr. Frank H. Lahey, chairman of the board of procurement and assignment service for doctors, said the armed forces now have 6.5 doctors for every 1,000 men, and there is one doctor for every 1,500 civilians.

"The ratio of doctors to civilians in America is much higher than it is in other countries," he said. "England now has only one doctor for every 2,700 civilians, and Germany is functioning with only one for every 12,000 civilians. The procurement service has surveyed the entire nation and is now sending doctors to areas reporting a shortage. So far we have dispatched 218 doctors to 154 communities in 29 different states."

Discussing the rôle the Public Health Service has played during the war emergency, Dr. Thomas Parran, surgeon general of the service, said that medical officers and sanitary engineers are being moved to spots where the shift of population into the war industry areas has created a health menace.

Dr. Parran also announced that quarantine hospitals for civilian carriers of venereal diseases are being set up. The Wesley Memorial hospital will handle Chicago cases, he said. At these quarantine centers all disease carriers will be isolated in an effort to protect men in the services.

Medical Students Might Graduate in Five Years

Chicago, Nov. 13—(INS.)—Suggestions for turning out graduate medical students five years after high

school were advanced in the Journal of the American Medical Association here as one way of increasing the number of physicians needed in the war effort.

The recommendations were adopted by the association's council on medical education and hospitals and would provide for "granting the M. D. degree within a period of five years after graduation from high school as contrasted with seven to eight years before the war."

Under the plan, required premedical education would be squeezed into two calendar years, the premedical course would be a qualifying year for the medical course and matriculated students would be recommended for enlistment or commission in the army or navy and remain on an inactive list until graduation.—Pomona *Progress-Bulletin*, November 13.

Sulfa Poisoning Being Overcome in Experiments

Advance in Fighting Effects Reported by U. S. Health Service

Washington, Nov. 22—(N.A.N.A.)—A possible long step forward in combating poisonous effects of sulfa drugs is seen in experiments just reported by the U. S. Public Health Service.

Perhaps the worst effect thus far reported is the development of the anemic condition known as agranulocytosis, or destruction of some types of white cells in the blood. A few years ago there was a national scandal when it was found that this was being caused by certain popular headache remedies. Victims almost always died.

But the agranulocytosis caused by sulfa drugs, apparently only in highly-susceptible individuals, can be stopped if treated in time, and thus far there have been no fatalities.

Doctors Clear Up Situation

Working to clear up the situation, Drs. S. S. Spicer, Floyd S. Daft, L. L. Ashburn and W. H. Sebrell, of the Public Health Service staff, fed rats with a scientifically adequate diet to which were added heavy doses daily of sulfaguanidine and a type of sulfathiazol.

For a few days there were no notable effects. Then the rate of growth of the young animals slowed down and soon growth stopped altogether. Agranulocytosis was produced with regularity, together with fragility of the blood vessel walls, several other serious blood conditions and a curious breaking out on the skin. The animals always died in a short time.

But, the Public Health Service doctors found they could prevent the agranulocytosis, other blood conditions and stoppage of growth entirely if they fed the animals, simultaneously with the sulfa drugs, regular doses of liver extract. The skin condition could be prevented entirely if they fed infinitesimably minute amounts of the B vitamin, biotin, most powerful of all psysiological substances.

Mechanism Still Vague

The mechanism of the reactions is still vague, the physicians report. There is a possibility, they believe, that the sulfa drugs, given in heavy doses, prevent the synthesis within the body itself of certain essential vitamins, some of which may still be unknown. It is possible that the biotin is synthesized in this way.

There is also the possibility that the drugs act as a direct poison on certain blood cells, and that this poison is counteracted by something in liver extract. It is also possible that the sulfa substances interfere with one or more of the extremely complex enzyme systems of the animal body which are basic in the phenomenon of growth.—Press *Dispatch*, November 20.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (29)

Alameda County (6)

Elizabeth Torrey Andrews, *Berkeley*
Clarence B. Foltz, *Oakland*
Roger W. Hackley, *Oakland*
C. B. Hills, *Berkeley*
Glenn A. Pope, *Oakland*
James A. Stark, *Oakland*

Fresno County (1)

John Francis Murray, *Fresno*

Inyo-Mono County (1)

Charles W. Anderson, *Bishop*

Sacramento County (3)

Charles E. Anzinger, *Sacramento*
George L. Browning, *Sacramento*
Henry E. Kleinsorge, *Sacramento*

San Bernardino County (1)

Joseph Perlson, *Patton*

San Diego County (2)

J. L. Barritt, *La Jolla*
Alfred C. Dick, *La Jolla*

San Francisco County (9)

Fred Cassius Blake, *San Francisco*
Julian Stanley Davis, *San Francisco*
Malcolm H. Finley, *San Francisco*
Vincent H. Greco, *San Francisco*
Fred Bernard Marasco, *San Francisco*
Thomas Tanton Nickels, *San Francisco*
Roland D. Pinkham, *San Francisco*
Otto E. L. Schmidt, *San Francisco*
John Francis Skelly, *San Francisco*

Santa Barbara County (2)

Hugh E. Stephens, *Santa Barbara*
William Gordon Winter, *Santa Barbara*

Santa Clara County (1)

Edward C. Sewall, *Palo Alto*

Shasta County (3)

William Lisle Bell, *Redding*
Maurice Leopold Lubin, *Weaverville*
Harry Raymond McVicker, *Redding*

Associate Members (1)

John B. Saunders, *San Francisco*

Transfers (2)

Egil Hanssen, from Fresno County to San Bernardino County
Richard D. Loewenberg, from San Francisco County to Lassen-Plumas-Modoc County

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Billingsley, Urban Clark. Died at Gold Run, November 15, 1942, age 67. Graduate of Cooper Medical College, San Francisco, 1904. Licensed in California in 1904. Doctor Billingsley was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Eder, Lawrence Frank. Died at Santa Barbara, October 11, 1942, age 42. Graduate of the University of Minnesota Medical School, Minneapolis, 1924. Licensed in California in 1928. Doctor Eder was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Ellis, Bertrand Le Roy. Died at Long Beach, October 31, 1942, age 30. Graduate of the College of Medical Evangelists, Loma Linda, 1940. Licensed in California in 1940. Doctor Ellis was a member of the Los Angeles County Medical Association, and the California Medical Association.

✤

Franklin, Edward Alfred. Died at Los Angeles, November 4, 1942, age 58. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1905. Licensed in California in 1921. Doctor Franklin was a member of the Los Angeles County Medical Association, and the California Medical Association.

✤

Gundrum, Frederick F. Died at Sacramento, October 23, 1942, age 62. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1908. Licensed in California in 1910. Doctor Gundrum was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✤

Heylmun, Harry H. Died at Long Beach, October 30, 1942, age 74. Graduate of Kansas City Medical College, 1897. Licensed in California in 1915. Doctor Heylmun was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Liljencrantz, Eric. (Commander, M.C., U.S.N.) Died at Pensacola, Florida, November 5, 1942, age 40. Graduate of Stanford University School of Medicine, 1929. Licensed in California in 1929. Doctor Liljencrantz was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

OBITUARIES

Ellis Harbert

1866—1942

On July 16, Dr. Ellis Harbert, one of the veterans of the San Joaquin County Medical Society, passed on to his final reward. He had been ill for over six years and totally incapacitated for many months preceding his death, which was caused by biliary cerrhosis with complications.

Dr. Harbert was born in Green Forest, Arkansas, on January 12, 1866, and his early education was in the elementary schools of his home town and at the private academy in Little Rock, Arkansas, where he prepared for Vanderbilt University School of Medicine from which he was graduated in 1893. After some postgraduate study in New York, Dr. Harbert came to California and located in 1897, at Waterford, remaining one year. In 1898 he opened offices in Stockton, and for short periods had as associates Dr. Daniel F. Ray and later Dr. James P. Hull. There were no hospitals in Stockton in 1898, and the kitchen table was used for operating. Partly due to Dr. Harbert's urgent requests Reverend Father O'Connor built the hospital, since known as St. Joseph's, and for the nearly forty years of his active practice, Dr. Harbert served on its staff.

For over twenty years Dr. Harbert was a member of the Stockton State Hospital Board. He was a great lover of the outdoors and duck hunting was his favorite sport. For indoor recreation he greatly enjoyed a guessing contest with his friends as to the value of the down card. In politics he was an ardent Democrat, and in religion was a liberal and one of the founders of the first Unitarian society in Stockton.

In his professional career, Dr. Harbert was primarily interested in surgery and through the years did a great volume of work and won the respect, confidence, and friendship of thousands. During the first World War when the Holt Manufacturing Company was the leading industry of this city, employing several thousand men, he was the company surgeon in addition to his large private practice. During the last years of his life when illness prevented active practice, Dr. Harbert utilized the trained skill of fingers in turning to wood carving, weaving, and other types of handiwork which he did with unusual skill.

The members of the San Joaquin County Medical Society extend their sincere sympathy to the surviving widow and daughter of their late esteemed and respected member.

DEWEY R. POWELL, M. D.

✤

Frederick F. Gundrum

1880—1942

Frederick F. Gundrum died at Sacramento, California, on October 23, 1942. Doctor Gundrum graduated from the Johns Hopkins University School of Medicine, Baltimore, in 1908, and was demonstrator in anatomy at the University of Pittsburgh in 1909-1910. He was certified as a specialist by the American Board of Internal Medicine; was a Fellow of the American College of Physicians. Dr. Gundrum was president of the California Academy of Medicine in 1937, vice-president of the State Board of Medical Examiners from 1913 to 1915 and of the California State Board of Health from 1915 to 1932. He was a valued member of the Sacramento Society for Medical Improvement, as well as past president and secretary of that Society. He served as chairman of the medical advisory board No. 7 during World War I; was director of the North California Branch of the State Laboratory from 1912 to 1915, and also chief visiting physician at the Sacramento County Hospital from 1910 to 1919, and secretary and member of the board of trustees of the Sutter Hospital.

During his years of practice in the Sacramento Valley, Doctor Gundrum made for himself a place in the hearts of patients, colleagues and fellow citizens—a place that will be hard to fill.

✤

Alfred Baker Spalding

1874—1942

Alfred Baker Spalding, 68, emeritus professor of gynecology and obstetrics in the School of Medicine of Stanford University, died at his San Francisco home Friday, Nov. 27. Dr. Spalding was widely known for the Spalding rule for the period of pregnancy, and for founding the San Francisco Home Maternity Service for persons of limited means. In failing health for some years, Dr. Spalding became emeritus from Stanford in 1930, and retired from active practice eight years ago.

He was one of Stanford's football immortals playing with the team that was coached by Walter Camp and managed by Herbert Hoover. Following his graduation from Stanford University in 1896, he attended Columbia University which awarded him the M. D. degree in 1900.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

News Items

In spite of the imminent gas rationing and tire shortage, Alameda County members are still responding one hundred per cent to the one day a month hospitality center service for men in the armed forces.

Three weeks in October were devoted to a letter campaign in support of the Basic Science Act. Although the Act was defeated, it is hoped that the ground work has been laid for a favorable return the next time it appears on the ballot.

Entertainment at the regular November meeting of the Auxiliary was furnished by Mrs. William H. Sargent, who sang a group of songs. Ena Louise Spencer, balloonist and parachutist, of London, England, talked about "England Under Fire."

Mrs. Floyd Bell, President, has announced that there will be no December meeting.

"Medical Morale" is the theme adopted for this year by the Woman's Auxiliary to the Los Angeles County Medical Association, and with this in mind, the opening business meeting was held on Tuesday, October 27, at 12:30, at the Chapman Park Hotel with Mrs. Franklin Farman, President, presiding.

Mr. Richard Atkinson, world traveler, author and member of the American Press Commission to Europe, gave a most interesting talk on "Russia and the World Today."

Honored guests were officers of the Los Angeles County Medical Association, namely: Dr. George D. Wells, President; Dr. Robert W. Wilcox, Vice-President, and Dr. Louis A. Alesen, Secretary and Treasurer.

Mrs. William R. Molony, Jr., Legislative Chairman, spoke briefly and introduced Mr. Ben Reed, Executive Secretary of the Public Health League of California, and Mr. Stanley Cochems, Executive Secretary of the Los Angeles County Medical Association. Mr. Reed spoke in behalf of Proposition No. 3, and Dr. Alesen lead a discussion and answered questions from the floor.

Mrs. Newell Jones, Chairman of Philanthropy, announced that Auxiliary members are to sell tickets for a drawing on March 23, 1943, on a $100 00 Defense Bond. This will be for the benefit of the Philanthropy Fund.

There is to be a District meeting held in Santa Ana on Friday, November 13, at which this Auxiliary will be represented.

A meeting of the Riverside Auxiliary was held on October 12th, at the Riverside Community Hospital. Mrs. Erwin Miller, program chairman, presided.

There were 12 members present and the evening was spent in rolling bandages for the hospital.

An appeal for help at the U.S.O. house was voiced by Mrs. H. J. Wickman. Mrs. H. W. Naockel asked for donations of used furniture for the Red Cross hospitals and recreation committees.

Plans for the distribution of information in regard to the Basic Science Act were discussed.

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† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Members of the Woman's Auxiliary to the Sacramento County Society for Medical Improvement were hostesses to the Eighth District at a luncheon, held at the Senator Hotel, on November 5th, at 12:45 p.m. Mrs. Manuel L. Azevedo, the newly-elected President of the Society, greeted the out-of-town guests.

Mrs. Charles Landis, of Chico, Councilor of the Eighth District of the Woman's Auxiliary to the California Medical Association, Mrs. F. G. Lindemulder of San Diego, State President of the Auxiliary, and Mrs. Ralph Eusdon, First Vice-President, were among the out-of-town guests who were entertained. Mrs. Landis presided.

The flower decorations were carried out in a Harvest theme, these being arranged by the Chairman of the Decorations Committee, Mrs. Lorenz Ruddy.

The members and new guests of the Society were greeted by the Hostesses Committee, under its Chairman, Mrs. J. Vincent Crawley, assisted by Mrs. Dan O. Kilroy.

The Woman's Auxiliary to the Humboldt County Medical Association met at the home of Mrs. Louis Weichselfelder, on Monday, November 2, 1942, at 8 o'clock p.m.

The meeting was called to order by the Vice-President, Mrs. B. M. Marshall.

It was decided that no meeting would be held in December, the next meeting to be at the home of Mrs. Joseph F. Walsh, on the afternoon of January 14, 1943. This meeting will be followed by a Tea to be given in honor of the visiting Navy and Army Medical wives and for the family members of the local Auxiliary. Mrs. Orris Myers was appointed as General Chairman for the occasion, with Mrs. John S. Chain, Jr., acting as her assistant. One of the duties of these two members will be to contact all Navy and Army Medical wives.

On December 7 to 14, inclusive, members of the Auxiliary will take turns as hostesses at the local U.S.O. Center.

Mrs. Walter Dolfini, Treasurer, has been authorized to turn over the proceeds collected from the two play readings, given by Mrs. Gordan Manary last spring, to the local Red Cross.

The Woman's Auxiliary to the Marin County Medical Society held its second meeting of the year, on October 22nd, at the Blue Rock Hotel, in Larkspur.

Following dinner, Mrs. Harry O. Hund introduced Dr. Isabelle Lewis Main, who told of the remarkable things that had been done in the past for the Chinese and the great need for food and medical care that now existed. Dr. Main spoke in behalf of the China War Relief. The members of the Auxiliary contributed generously to the cause and also voted to take money from the treasury to donate to the drive.

The business meeting was held following the program, Mrs. Rodney B. Hartman, presiding. It was announced that Mrs. Lindemulder, State President, would be in Santa Rosa, November 4th, to meet with the Auxiliaries of Sonoma, Solano, Marin and Medocino-Lake Counties.

Dr. John Cline, President of the San Francisco County Medical Society, addressed the Woman's Auxiliary at their October meeting. Dr. Cline spoke on the importance of passing the Basic Science Act.

Dr. Maurice L. Tainter, Professor of Pharmacology at the Stanford Medical School, discussed the "Revolution in treatment caused by Sulfanilamide."

About 65 members heard the speakers and attended the

business meeting which followed. Mrs. Raleigh Burlingame, President, presided. Mrs. Norman Morgan, Hospitality Chairman, who arranged the Tea, was assisted by Mrs. Thomas Gibson, Mrs. William Reilly, and Mrs. Paul Wyne.

One of the projects of the Auxiliary this year is assisting at the San Francisco County Medical Society's Blood Bank. Mrs. Howard Dixon is Chairman of the Motor Corps; Mrs. Guy Schoonmaker, Canteen; Mrs. Roger McKenzie, Technician's Aides. These departments are all staffed by Auxiliary members.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Industrial (September)		37,871
Rural Health Program		1,500
War Housing Projects (December 1st) (Approximate)		6,500
Vallejo	2 000	
Marin	3 200	
San Diego	1,500	

C.P.S. has recently signed contracts with the Housing Authorities of Marin County, Vallejo and Los Angeles. These authorities are providing housing to bona fide war workers. The estimated population to be covered under the medical and hospital plan will be approximately 100,000 persons. This is a tremendous responsibility for the medical profession of California. A good job must be done. *Every physician in California is committed to help make this a success.*

There are far-reaching implications in this endeavor in which governmental agencies have turned over and have given to a state-wide organization of the medical profession the opportunity to do its part in the war effort. *Failure* can only mean that some one else must do the job—and that can only mean the government. *Success* will mean satisfaction in having made a valuable contribution to war production, plus an unpredictable advantage in leadership in the field of medical economics for the population as a whole.

* * *

JUST A FEW THINGS TO THINK ABOUT

Who will provide the medical care for:

250 000 war workers in California now, and the x number, 6 months from now?

The 150 000 migrating within the state?

Continuous westward migration of labor of all kinds?

New cities being built by Federal Public Housing Authority without regard to supply of physicians or hospital facilities?

Metropolitan population increasing rapidly?

When it is known that:

California's quota to armed forces remains the same.

Many rural communities are already without enough physicians.

Many metropolitan practices stretched to the breaking point.

Resident population getting jittery.

New housing projects with no medical facilities whatsoever.

Shall it be:

Readjustments on an individual basis?

War Manpower Commission?

National Housing Agency?

United States Public Health Service?

Legislation?

or

OURSELVES?

A. E. LARSEN, M. D.,
Secretary-Medical Director.

* * *

CALIFORNIA PHYSICIANS' SERVICE
153 Kearny Street
San Francisco, California
BULLETIN OF OCTOBER 30, 1942

Financial operations for the month of August were as follows:

Dues collected		$51,663.74
Late dues and unused portion of prior allocations		308.11
Professional member dues		65.00
		52,036 85
Cost of Administration		9.779.52
Available for August business		42 257.33
Available for remaining professional services		30 314 38
X-ray and lab. on hospitalized patients		2.942.95
29,807.8 units of service		38 750.14
Transferred to Unit Stabilization Fund		564 24
Previous balance in Fund		24 611 69
Total Unit Stabilization Fund		$25,175.93

* * *

BULLETIN OF DECEMBER 1, 1942

Financial operations for the month of September were as follows:

Dues collected		$49,365.51
Late dues and unused portion of prior allocations		738 88
Professional member dues		105.00
		50 209 39
Cost of Administration		12 202.18
Available for September business		38 007 21
X-ray and lab. on hospitalized patients		2.584.68
Available for remaining professional services		35 422 53
25,645.1 units of service		35,903.14
Transferred from Unit Stabilization Fund		480 61
Previous balance in Fund		25,175.91
Total Unit Stabilization Fund		$24,695.32

* * *

One Wartime Medical Care Problem Solved by the Medical Profession Itself: Some Excerpts from FPHA Bulletin, Published by Federal Public Housing Authority, Washington, D. C., No. 19, of November 10, 1942

"A prepaid medical service plan for war housing tenants is in operation at the Marin City project of the Marin County Housing Authority in California. The plan includes complete medical care, surgery, and hospitalization furnished by agreement with the California Physicians' Service, a nonprofit organization which op-

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

erates a state-wide prepayment medical service sponsored by the California State Medical Association.

"Membership in the plan is voluntary on the part of tenants. . . . There has been enthusiastic response from the Marin City project tenants. Thus far 600 families and 1,100 single men already living there have joined the plan. Tenants pay a monthly fee of $5 per family with children, $4 for a two-person family, and $2.50 for a single person.

"The plan grew out of the wartime necessity to assure medical care for in-migrant war workers and their families. Not only have those families been cut off from family physicians in their former communities, but the induction of doctors into military service has curtailed medical services in the communities in which they are now living. A further factor is the necessity to supply medical services which will help to prevent the spread of contagious diseases among highly concentrated populations in war production areas.

"Authorities in other California cities and towns are eager to participate in the plan and procedures for their inclusion are being prepared. Coöperating with FPHA and local housing authorities is the United States Public Health Service. All three have combined responsibility in arranging medical care for families living in public housing projects.

"The plan includes a medical center in the project, supplied with proper medical and nonmedical equipment, and staffed by nurses and resident physicians."

A. E. LARSEN, M. D.,
Secretary-Medical Director.

Housing Project Renters to Get Free Medical Care

Vallejo, Nov. 16.—Complete medical care as a routine service included in the weekly rent bill will be offered starting today to 800 Mare Island Navy Yard workers and their families living in Vallejo's Victory Apartments in an experiment which may show the nation how to solve the health problem in over-crowded defense plant areas.

The service, if it proves itself, will be extended to the 10 to 12 thousand persons soon to occupy Chabot Terrace and later to Federal Terrace, Lincoln Highway dormitories, and other Federal housing projects under jurisdiction of the Vallejo Housing Authority.

The Vallejo undertaking, with a similar experiment under way with 4,000 residents of Marin City at Richmond, will be under the scrutiny of Government experts charged with protecting millions of defense workers from war-born pestilence.

The nearly 3,000 workers, wives and children in Victory Apartments, located west of Fourth Street from Rayland Street to the Southern Pacific tracks, will have every medical service, including 21 days of hospitalization at their disposal for the asking. Utilization of the service will be optional and doctors in charge will coöperate to the fullest extent with physicians of the Solano County Medical Association and Vallejo Academy of Medicine who are in large part responsible for the experiment.

Offices, staffed by doctors and nurses assigned by the Doctors Procurement and Assignment Service of the War Manpower Commission, will be opened at 516 Ryder Street. Dr. Albert E. Larsen, medical director of the California Physicians' Service, which will handle the project, said the office would be opened today.

This announcement was made after a conference with Maurice Wilsie, executive manager of the Vallejo Housing Authority, Dr. E. R. Mills of the district office in San Francisco, Dr. M. A. Dexter of the Solano County Medical Association, John A. Bohn, executive manager of Chabot Terrace, and Larry Wise, head of the Vallejo Housing Authority department of project services.—Oakland *Tribune*, November 16.

Workers to Pay Medics with Rent

San Francisco (INS.)—Several thousand families in California war-plant industrial communities now pay their doctor bills in advance, and with their rent. And within a few weeks 35,000 California farm families will be adopting a similar prepayment plan which last year reduced farm medical costs in three experimental counties to between $10 and $20 a year per person.

The urban coördination of rental and medical charges has been inaugurated in Sausalito, San Diego and other cities which have large housing projects for war workers. The housing authority turns the money for medical service over to the California Physicians' Service, which assigns doctors and nurses and maintains clinics.

These innovations are only two of many which war conditions are effecting in medical and hospital practice in Pacific Coast states now coping with a double threat to public health—sudden boom town gains in population and the loss of a high percentage of young physicians and surgeons to the armed services.

Deduct Charges

Some of the big-scale employers—notably Henry J. Kaiser—have elaborated and extended the system of deducting charges for medical check-ups from the wages of their workers.

Executives of crowded hospitals are refusing to accept patients who can be treated in their own or nursing homes.

Hard-pressed physicians and surgeons are discussing establishment of district medical centers. These would eliminate many medical calls at private homes. Only the seriously ill who were also bedridden would receive such calls. Other patients would have to go to the doctors at the nearest medical center.

Facing the virtual certainty that the coming winter months will increase the incidence of colds, pneumonia and influenza, clubs and civic organizations are sponsoring public instruction in standard methods of health protection and home nursing.

While these steps are being taken to reduce disease hazards in the cities and towns, a new program to extend adequate medical service to the low-income group of California farmers will become effective shortly. Under its provisions, as announced by the farm security administration and the California Physicians' Service, any farm family with a net yearly income of $2,000 or less may join the coöperative group. About 35,000 families, or 130,000 persons, are being offered membership.—San Jose *News*, November 11.

Health Aid to Low Income Farm Groups

Group Action Follows Forming Associations Program to Benefit

Benefits of the rural health insurance program offered by the California Physicians' Service are open to families whose incomes are at least 50 per cent from agricultural sources and the net of which as reported for 1941 State income tax did not exceed $2,000, upon certain group action by a sufficient number of these families in any given locality. Coverage does not actually begin until membership cards are received by the family members from the physicians' service.

The group action involves the formation of a farmers' health association which enters with the physicians' service into a contract known as "The Rural Health Service Agreement." A constitution and by-laws to govern the association are drawn up by the organizing committee, acting as a temporary board of directors. Each family applying for membership, signs on the application a pledge to abide by this constitution and by-laws.

Membership Dues

Membership dues for participation in the insurance program, plus a small amount for the running expenses of the local association, are payable by check or money order made in favor of the California Physicians' Service and held by a trustee until the close of the period for receiving dues, at which time they are sent as one fund from the farmers' health association to the physicians' service headquarters, at 153 Kearny Street, San Francisco. There the physicians' service acts as a trustee for its physician members, paying them monthly on a unit basis for the services they report as having rendered the previous month to participants in the insurance program. The portion of the fund that represents dues for running expenses of the local association is returned to the treasurer of the association.

List Members

Accompanying the fund which is sent from the farmers' health association to the physicians' service are the applications for membership and a list of the families whose applications and dues are included. The applications, containing the names of members of each family, are used for making the membership cards for each person in families whose applications are approved. The name of any family whose eligibility is questioned by the local organizing committee or local physicians' reviewing board is starred on the list, and the physicians' service may request that family for a copy of their 1941 income tax

report or for other information to determine their eligibility.

The presentation of the individual membership card to the physician at the time he renders services included under the coverage of the insurance program authorizes him to send his bill, in the form of a statement of services rendered, to the physicians' service instead of to the family.—Madera *Tribune and Mercury*, October 26.

Health Insurance

Medical Care Included in Federal Rent

"Now," said the rental agent, "here is a lovely apartment—plenty of room for you and your family, completely furnished, and the rent is only $45 a month—including complete medical and hospital care in case of illness."

Here is modern health insurance—doctor bills paid in advance, as part of the rent.

It is already in effect for 8,000 California war workers in Federal war housing projects, and will eventually spread to an estimated 100,000 or more.

Contracts Revealed

Its development was revealed here yesterday by Dr. A. E. Larsen of California Physicians' Service, following completion of contracts in four war centers.

The first district takes in thousands of airplane workers in San Diego, the second covers all Marin county, including Marinship and Hamilton Field, the third involves shipbuilders and aircraft workers in Los Angeles, and the fourth takes in 1,000 families in the Vallejo district.

"The San Diego project was our guinea pig," Dr. Larsen said, "We actually were planning it before the war, and signed the contract this May. That's where we learned our lessons."

In each case, the agreements were made by C.P.S. and local physicians' groups with the Federal Public Housing Authority and the local housing authority.

The cost of protection is $2.50 a month for a single worker, $4 for a man and wife, and $5 for a man, wife and family.

Only those living in war housing projects are entitled to this type of coverage, although other C.P.S. contracts have been made recently with industrial and agricultural groups.

Doctors Collected

The medical contracts for residents of war housing projects provide complete medical and hospital protection with only two limitations—no more than 21 days' hospitalization for any single illness, and no more than $5 per day for hospitalization in maternity cases.

Patients with minor illnesses are treated in the clinic provided at each housing project. If their illness is serious, they are advised to consult a private doctor of their own choice, or—if they have one—their family doctor in the neighborhood.

To staff the clinics, Dr. Larsen said, it has been necessary to hire local men where available or bring outside doctors into war-booming communities.

Many doctors have been "collected" from ghost towns, where nearly all the residents have gone away to the shipyards, and brought to Vallejo, Sausalito or Los Angeles.

Alien physicians, unable to secure commissions in the Army or Navy Medical Corps, have been given vital jobs in caring for war workers.

Morale Builder

Some of these newly recruited men are giving full time to their patients in housing projects, while others are spending part time on them and part time on their private patients.

Dr. Larsen declared the new arrangement has aided in building morale, decreasing lost time due to illness, and sparing workers from the shock of the cost of sudden illness.

"This is not State medicine," he said. "It merely shows that the medical profession has found a way of working with the Government."—San Francisco *Chronicle*, December 11.

The Doctor's Bill.—An editorial appeared some time ago in *America* in which a survey by the Metropolitan Life Insurance was quoted and which showed that the average annual payment for the average family to its physicians is $140.00. The figure may be accurate but it gives no hint to the usual long delays after the service was rendered before payment was made. The commentator makes the following remarks.

"Now the cost of repairing the human machine engenders one of the most interesting problems of the day. It is a most important factor in the family budget. From very many parts of the country the report has come that, after the bill for medical services has been rendered, the family physician, who floated into the house with healing upon his angelic wings, assumes the menacing part of a Shylock.

"That medical, hospital, and surgical fees do impose a terrific burden upon some families is beyond all question. To many a man working for a salary, the physician's order to go to a hospital for an operation, is worse than a decree in bankruptcy. It means, in many instances, the loss of his job, and a period in which bills pile up so high that he must work for the rest of his life to pay them.

"This fact is recognized by the profession. For several years medical, surgical and hospital committees have been surveying the field, and as they are animated by an honest purpose, we can rely upon an accurate and intelligent diagnosis of ,a very serious social problem. But it has already become apparent that the reason of many a heavy hospital bill is the fact that the patient and his family have demanded unnecessary, and even luxurious, accommodations, and special service. Even when they are sick, some people never lose their ambition to keep up with the family of Jones.

"One aspect of this problem should not be lost sight of. If some physicians demand, and collect, exorbitant fees, others never receive the modest fees which they ask. Every profession has its list of nonpaying clients, but the physicians probably have the longest catalogue. Men who have been snatched from Mr. Toots would designate as the Cold and Silent Tomb, are so jubilant that they are quite unable to think of anything so prosaic as a bill for professional services rendered. Besides, now that the crisis is safely passed, they are too busy arranging a vacation trip.

Medical and Hospitalization Benefits for Veterans of World War II.—S. 2726, introduced by Senator Clark, Missouri, August 20, and pending in the Senate Committee on Finance. A bill to amend Section 6 of Public Law No. 2, Seventy-third Congress, March 20, 1933, as amended.

Comment.—The purpose of this bill is to accord to the veterans of the present war the medical and hospitalization benefits made available to veterans of World War I.

"On the Side."—A paragraph from the Column of E. V. Durling:

Queries from clients. Question.—I would like to ask you a fair question. If a doctor is doctoring a doctor, does the doctor doing the doctoring, doctor the doctor the way the doctor being doctored wants to be doctored or does the doctor doctoring the doctor doctor the doctor the way he usually doctors?

Answer.—As I understand it the doctor doctors the doctor the way he thinks the doctor should be doctored, but while the doctor doing the doctoring is doctoring the doctor, the doctor being doctored demands that the doctor doctor him the way he, the doctor who is being doctored demands. The doctor doing the doctoring and the doctor being doctored then get into an argument about the doctoring. This aggravates the doctor being doctored, and the doctoring done by the doctor doing the doctoring is of no avail. That is why doctors die younger than other people. I hope I make myself clear.—San Francisco *Examiner*, September 4.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles. Sunday, May 2, 1943, and Monday, May 3, 1943.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title, "Your Doctor and You."

In December, KFAC will present these broadcasts on dates of December 5, 12, 19, and 26.

The Saturday broadcasts of KECA are given at 10:30 a.m., under the title, "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Pharmacological Items of Potential Interest to Clinicians*:

1. *New Books:* Some of Hans Zinsser's thoughtful poetry appears in his *Spring, Summer and Autumn*, just published by Little Brown. J. Needham edits an important series of essays on Comenius, "The Teacher of Nations" (Cambridge). W. N. East discusses "The Adolescent Criminal" (Churchill, London, 1942). C. D. Darlinton reviews "Recent Advances in Cytology," and Churchill also issues an "Outline of Town and City Planning." Seventh edition of J. Glaister's "Medical Jurisprudence and Toxicology" appears (Livingstone, Edinburgh, 1942). R. A. Kilduffe and M. DeBakey discuss the "Blood Bank and Technique and Therapeutics of Transfusion" (Mosby, St. Louis, 1942). G. A. Bennett, H. Waine and W. Bauer write on "Changes in Knee Joint at Various Ages" (Commonwealth, N. Y., 1942). J. S. Lundy offers a volume on "Clinical Anesthesia" (Saunders, Phila., 1942). R. A. Leonardo writes a "History of Gynecology," a "History of Surgery," and "An American Surgeon Abroad" (Froben, N. Y., 1942). A. A. Werner's "Endocrinology" (Kimpton, Lond., 1942), stresses relation of endocrines to Autonomic Nervous System. Second revision of Merck's, *Treatment of War Injury* is O.K.—ask for a copy.

2. *Nutrition:* Oleanders (like orchids), to F. J. Stare and Nutrition Foundation for issuing *Nutrition Reviews* (Vol. 1, No. 1, Nov., 1942). F. W. Quakenbush, et al (*J. Biol. Chem.*, 145:169, 1942), note that tocopherol prevents oxidation of carotene in oil solutions. P. Handler and W. Dean (*Ibid.*, p. 145), indicate that pellagra involves dysfunction of adrenal cortex. B. Wood, B. Splatt and I. Maxwell (*Med. J. Austral.*, 2:263, Sept. 19, 1942), observe that thiamine hastens emptying of stomach, but does not affect gastric secretion in man.

3. *Aviation Medicine:* Have you seen the remarkable "Compendium of Aviation Medicine," by S. Ruff and H. Strughold, with Introduction by E. Hippke, Chief of Medical Staff of German Air Corps, and translated and issued under license of the Alien Property Custodian? J. C. Stickney and E. J. Van Liere (*J. Avia. Med.*, 13:170, 1942), note that short exposures to low oxygen tension may produce some acclimatization. E. J. Van Liere and G. A. Emerson (*Ibid.*, p. 182), find that quinine, atabrine and plasmochin have no influence on lethal effects of anoxia.

4. *Cancer:* H. Blum, et al (*J. Nat. Cancer Inst.*, 3:83, 1942), make important survey of limits of accuracy in experimental carcinogenesis. A. Taylor, M. A. Pollack and R. J. Williams (*Science*, 96:322, Oct. 2, 1942), report that various types of malignancy tend to have similar cellular metabolism, forming a common tissue type. F. Dickens and H. Weil-Malherbe (Newcastle, Eng.), note possible carcinogenic activity of wood smoke (*Cancer Res.*, 2:680, 1942). Last June's Endocrine-Cancer Conference is reviewed in the October issue of *Cancer Research*.

5. *Infections:* H. C. Souza-Araujo (*Mem. Inst. Oswaldo Cruz*, 37:95, 1942), offers evidence that certain

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School, Galveston, Texas.

species of ticks may transmit leprosy. *Med. Res. Counc. Sp. Rep.*, 245, 1942, reviews ecology of bed-bug infestation and finds heavy naphtha best for control. B. Sjogren (*Nature*, 150:431, Oct. 10, 1942), says he's making naphthoquinone sulfonamids for chemotherapy of tuberculosis. L. Arnold (*J. Inves. Dermatol.*, 5:207, 1942), gives neat report on physico-chemical changes in cornified layer in relation to endogenous bacterial flora of skin, finding that alkaline moisture increases bacteria, while acid dryness decreases them. C. H. Rammelkamp (*War Med.*, 2:830, 1942), finds (like California dermatologists), that tyrothricin is useful in local staph and strept infections. An admirable item in geographical medicine is A. A. Moll and Mrs. S. O'Leary's series of reports on Plague in the Americas in recent issues of the *Bulletin of the Panamerican Sanitary Bureau.*

6. *Notes:* "Evans Blue" (T-1824), again is recommended for estimations of blood volume in man by L. J. Davis (*Edin. Med. J.*, 49:465, 1942), here's to Herbert! L. L. Miller and G. H. Whipple (*J. Exp Med.*, 76:421, 1942), note that methionine protects against protein depleted susceptible liver injury from chloroform, even when given 3 hours after anesthesia. E. Rothlin (*Schweiz. Med. Woch.*, 71:1526, 1941), finds phosgene absorbed from lungs and that systemic poisoning may be antidoted by calcium and ergotamine.

Final Vote on Proposition No. 3 (Basic Science Initiative).—On page 335 of the November issue of CALIFORNIA AND WESTERN MEDICINE appeared a summary of the vote by California Counties on the Basic Science Initiative up to November 5, 1942. Reply to a letter sent to the Secretary of State on December 11th contained the information that the total vote on Proposition No. 3 (Basic Science Initiative) was: In favor of No. 3, 584,324. Against No. 3, 1,132,957. The measure was defeated by a total of 548,633 votes.

A.M.A. Court Decision to Get U. S. Supreme Court Review.—The Supreme Court on October 12th, agreed to review a decision holding the American Medical Association guilty of violating the Sherman Anti-trust Law by alleged activities against a group-health organization in the District of Columbia.

Granting of the Medical Association's petition meant that the tribunal would hear oral arguments in the case and then would deliver a formal opinion. Denial of a review leaves in effect the decision of the lower court.

The Medical Association, joined by an affiliate, the Medical Society of the District of Columbia, sought a review of an adverse decision by the United States Court of Appeals for the District of Columbia. This decision upheld a $2 500 fine against the National Association and a $1 500 fine against the local society.

The Association contended that practicing medicine was a profession, not a trade, and hence could not be prosecuted under the Sherman Act, which prohibits activities "in restraint of trade."

The medical organizations were accused of conspiring against Group Health Association, Inc., described as a nonprofit coöperative association of Government employees.

Gas Rationing.—The staff of the California Hospital, at Los Angeles, has issued a special bulletin on gas rationing for physicians. For the information of readers, excerpts follow:

"Most of these questions regarding gas rationing were secured through the courtesy of C. W. Decker, M. D., in coöperation with the Automobile Club of Southern California. It is, therefore, issued for your information.

"*Gasoline Ration:* Your 'A' book represents 90 miles of so-called 'family driving,' i.e., to church, to the market, etc. All the balance of the 'A' book is for essential driving in professional service. The 'C' book covers strictly professional service driving only, with coupons for the stated mileage given by you in your application. Each ration book is computed upon a rate of 15 miles per gallon of gasoline.

"Few, if any cars, as they must be driven by the physician, with frequent stops and starts, can give 15 miles to the gallon efficiency. To obtain additional gas, Federal Regulations for gasoline rationing provides in Sec. 8053, that holders of the 'C' book finding their allowance not sufficient to travel the mileage stated in their application, may make application to their Ration Board for a supplemental allowance, in addition to that given by the 'A' and 'C' books.

"To qualify for such additional allowance, the Legal Department of the Automobile Club of Southern California advises:

"(a) Keep exact record of speedometer mileage, at beginning of ration period, having this verified by the proprietor of the service station supplying you with gasoline.

"(b) Record of mileage traveled, and sales slips showing number of gallons of gasoline consumed, in a 30-day period, with verification as in (a).

"(c) With this data, go to your Ration Board, obtain form for supplemental allowance of gasoline.

"The Board will give any other instruction required, that you may properly complete your application."

Dr. H. S. Rogers, Past President of C.M.A. is Cited for World War Injuries.—The following item appeared in the Petaluma *Argus-Courier*, November 9, 1942:

Dr. H. S. Rogers, World War I veteran and prominent local physician and surgeon, Saturday received from the quartermaster-general's office in Philadelphia upon order of the adjutant-general's office in Washington, D. C., the purple heart cross, citation for injuries received in action Sept. 26, 1918, in the Argonne forest on Vaqui hill.

The cross, struck in gold, has a bas-relief figure of George Washington in white on a purple field. On the reverse side is inscribed, "For meritorious army service."

In acknowledging receipt of the citation, Dr. Rogers pointed out that its arrival is timely with the celebration of Armistice day.

Urology Award.—The American Urological Association offers an annual award 'not to exceed $500' for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, May 31-June 3, 1943, Hotel Jefferson, St. Louis, Missouri.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 1, 1943.

California Board of Medical Examiners: Secretary Pinkham Will Retire.—Another veteran who plans to retire soon is Dr. Charles Pinkham, secretary of the State medical board for the past 30 years. He was re-elected for another term when the board held a three day meeting in Sacramento but indicated he would retire next February, when he reaches the mandatory age limit for leaving State service.* Dr. Percy Dolman, of San Francisco, was named president, succeeding Dr. Fred De Lappe of Modesto. The new vice-president of the board is Dr. George Thomason of Los Angeles.—Vallejo *Times-Herald*, October 29.

Comparative War Losses.—Here is a box score of the first year of war's toll of Japanese and American ships in the Pacific and the Far East, as announced by official United States communiques.

The list includes only ships announced as sunk, eliminating apparent duplications. Those probably sunk or damaged are omitted in this comparison because damage to American warships usually is not announced. Furthermore, many enemy ships announced as damaged undoubtedly have been repaired and put back in service, and the damage total probably includes several instances of a single ship being damaged several different times, with each occasion announced as damage to an enemy ship.

The box score of ships sunk:

	Japanese	U. S.
Battleships	3 *	2 ‡
Carriers	6	4
Cruisers	27	7
Destroyers	58 †	22
Submarines	12	5
Plane tenders	1	1
Minesweepers	3	7
Transports	59	6
Tankers	20	3
Merchant ships, cargo, supply, etc.	80	13
Miscellaneous noncombatant	16	2
Miscellaneous warships	21	13
Total	306	85

Highlights of War

Washington, Dec. 1.—Highlights of a year of war:

Announced American Casualties

	Dead	Wounded	Missing	Prisoners	Total
Army	1,214	1,531	29,668	178	32,591
Navy	4,117	1,424	8,140	462	14,143
Marines	775	722	1,900	728	4,125
Coast Guard	37	11	126	...	174
Merchant Marine	463	11	2,438	24	2,925
Total	6,606	3,688	42,272	1,392	53,958

Size of Armed Forces

	Dec. 7, 1941	Dec. 7, 1942
Army	1,800,000	4,800,000
Navy	325,000	1,100,000
Marines	60,000	210,000

War Production

	1941	1942
Aircraft (number)	14,000	49,000
Merchant Ships (tons)	1,640,000	8,200,000

Pacific Shipping and Naval Losses

	U. S.	Japan
Naval Ships Sunk	61	131
Non-Combatant Ships Sunk	24	175

Battle of Western Atlantic

U. S., Allied and Neutral Ships Sunk	591
Axis Submarines Sunk	?

* One may have been a heavy cruiser; one was the Haruna, announced as sunk by the Army early in the Philippines campaign, but the claim since has been questioned.

† Two may have been cruisers.

‡ The Arizona and Oklahoma, sunk at Pearl Harbor. Oklahoma listed as sunk, since Navy has not yet decided whether to go ahead now with righting her and putting her back in commission.

The list includes American ships which were scuttled to keep them from being captured by the enemy as well as ships lost by accident.

—San Francisco *News*, December 7.

* Doctor Pinkham will retire as Secretary, but not as a member of the Board.

Radio Broadcasts: "Doctors at War."—American Medical Association dramatized radio broadcasts in cooperation with the National Broadcasting Company will be resumed Saturday, December 26, at 5 p.m. eastern time (4 o'clock central time, 3 o'clock mountain time, 2 o'clock Pacific time). The title of the new series will be "Doctors at War: Book III of Doctors at Work."

Doctors at War will be broadcast with the official approval and coöperation of the Medical Department, United States Army, and the Bureau of Medicine and Surgery, United States Navy. Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, will appear on the program on a selected date. The broadcasts will be a continuation of the story of Doctors at Work, carrying the fictitious but typical American physicians into the military and naval services of the United States and following the development of the practice of medicine in typical American communities affected by industrial expansion, troop programs and other wartime influences.

As in past years, the program will be dramatized. Scripts will again be written by William J. Murphy, continuity editor, central division, National Broadcasting Company. Production direction, actors and music will be from the broadcasting company staff. Time is donated and production costs are shared by the National Broadcasting Company.

Prize Offered for Paper on Glaucoma.—The National Society for the Prevention of Blindness announces that a prize of $250 will be awarded for the most valuable original paper during 1943, adding to the existing knowledge about the diagnosis of early glaucoma. The award will be made by the Society with the guidance of an ophthalmological committee composed of Dr. Arnold Knapp, Dr. Manuel Uribe Troncoso and Dr. Mark J. Schoenberg.

Papers may be presented by any ophthalmologist, student in ophthalmology or research worker of the Western Hemisphere and may be written in English, French, German, Italian, Spanish or Portuguese, but those written in the last four languages should be accompanied by a translation in English. Papers should be in the office of the National Society for the Prevention of Blindness, 1790 Broadway, New York City, by September 15, 1943.

Highlights of the Hot Springs National Venereal Disease Conference, October 21-24, 1942.—Although there has been a steady decline in the venereal disease rates for the years 1939-1942, inclusive, the incidence of venereal diseases is still too high with a resultant loss of man-power to both the armed forces and industry: 57,000 selectees of the first 2,000,000 examined were rejected as unfit for military service because of venereal diseases; 300,000 workers engaged in war industries are infected with syphilis alone.

There is a definite responsibility for (1) Repression of prostitution; (2) Rehabilitation of the girls engaged in this activity; (3) Prevention of prostitution. More than 300 communities employing repression have shown a 75 per cent decrease in the work of the prostitute.

Treatment of early Syphilis: The high rate of delinquency in patients and the needs for rendering patients noninfectious have led to several schedules of treatment which embody the factors of therapeutic efficiency, limited toxicity and adequate margin of safety. The Harry Eagle Plan, a ten-week intensive schedule, is a compromise between the vexatious eighteen-month schedule, as now employed, and the dangerous 5-day drip method. The Army Plan, commonly referred to as G.O. 74, extends over a six-month period, during which 30

arsenicals and 16 Bismuth injections are given the patient. This schedule lends itself more easily to adoption by the private practitioner.

It should be mentioned that all plans, 10 day or less in duration, are experimental and dangerous. In all schedules of treatment careful examinations and frequent follow-up over a period of time are of utmost importance.

Legislation in 1943: Re Crippled Children.—The California Society for Crippled Children, as one of the original sponsors of the Crippled Children's Act (Health and Safety Code, Chapter 2, Article 2) passed by the Legislature in 1927, has always had a great interest in the work being done for crippled children through this Act by the State Department of Public Health. Our own observations confirmed by information received from the State Department of Public Health, make it obvious that certain changes and additions to the California law relating to crippled children are necessary at this time.

The proposed amendments to the Health and Safety Code which we intend to draw up and submit to the legislature are as follows:

1. An enabling provision specifically allowing the State Department of Public Health to accept financial assistance from the Federal funds made available through the Social Security Act for providing care for crippled children, and to coöperate with the Federal government and other agencies in developing this program.

2. An amendment to change the upper age limit for crippled children from eighteen to twenty-one years in order to conform to the Social Security Act.

3. An amendment allowing the State Board of Health to set minimum standards for the quality of care to be provided for children through this program.

4. An amendment to provide for a State appropriation for the purpose of providing care and administering the Crippled Children's Act. At the present time the program is supported approximately as follows:

Federal funds	59 per cent
County funds	39 per cent
State funds	2 per cent

We believe that a sufficient amount should be appropriated so that the combined State and County funds would at least equal 50 per cent of the entire program. This would require about $50,000.00 per year.

New Psychiatric Service.—The San Francisco Department of Public Health, announces the opening of the psychiatric service of the San Francisco City Venereal Disease Clinic. The San Francisco City Clinic is located at 33 Hunt Street, San Francisco. The psychiatric service is established as a special field study project by the United States Public Health Service and offers the only psychiatric service of this type which has been established in direct conjunction with a venereal disease clinic in the United States.

The service will be based on an entirely individualized case study plan.

Those cases which show maladjustment will be referred to the psychiatric service.

No residence or financial requirements prevail in so far as the psychiatric service is concerned, and the service is in position to consider cases referred from outside sources. Arrangements will be made with various nonofficial agencies to provide funds in certain instances to carry out recommended psychiatric treatment plans. Attempts will be made to relocate the patients through coöperation of official and nonofficial agencies concerned.

The medical director of the San Francisco City Clinic is the Chief of the Division of Venereal Diseases, Dr. Richard A. Koch. The Director of the Psychiatric Service of the clinic is Dr. Ernest G. Lion, who is instructor of psychiatry at the Stanford University School of Medicine. The personnel of the psychiatric service will consist of the psychiatrist, a chief psychiatric social worker, an assistant psychiatric social worker, and two clerks.

Sigismund Shultz Goldwater, M. D.—Dr. Sigismund Schultz Goldwater, Commissioner of Health of the City of New York in 1914-15, died in his sixty-ninth year at Mount Sinai Hospital, on October 22. To him was largely due the credit for the rehabilitation of the hospital system of the City of New York. While Commissioner of Hospitals, he helped to plan and supervise the construction of Welfare Hospital for patients with chronic diseases. Always a forceful character, he fought continually for progressive medicine and for improvement in hospital construction. At the time of his death he was an advisory construction expert for 156 hospitals in United States, Canada, Newfoundland, and British Columbia. He was not only a physician but a registered architect and an honorary member of the American Institute of Architects as well.

From 1934 to 1940, Dr. Goldwater was Commissioner of Hospitals, and upon his retirement in 1940, he became president of the Associated Hospital Service. He established the community ward plan for medical service. He had held honorary and official positions and had written extensively, particularly in the fields of hospital construction and public health service. At various times he had been president of the American Hospital Association, chairman of the Council on Community Relations and Administrative Practice, and a member of the editorial board of the *Modern Hospital*.

By his death, the Medical Society of the State of New York has lost one of its most distinguished members and the profession of medicine a valiant fighter for progress.

Research Grants to Stanford Medical School.—Research grants amounting to more than $5 000 have recently been received by Stanford University in support of tropical disease studies being carried on by the University.

E. P. Mumford, research associate, is directing the Stanford research project which is an investigation of the geographical distribution of insects and other disease carriers, and of the parasites of man in relation to the war and its aftermath. The study is being made with special emphasis on the Pacific islands with which Mr. Mumford has been concerned in his research at Stanford since 1939.

Recent grants for the tropical disease research include $4 000 from the Josiah Macy, Jr. Foundation $850 from the Carnegie Corporation of New York, $400 from the National Academy of Sciences, and $200 from the May Esther Bedford Fund, Inc., of Connecticut.

Other subscribers to this coöperative project at Stanford are the Higher Studies Fund at Oxford, the British Association for the Advancement of Science, the Ella Sachs Plotz Foundation, and the Viking Fund.

Mr. Mumford recently published two papers on malaria and the plague in the Pacific, and is now at work on similar articles on parasitological problems of the Pacific in relation to the war and its aftermath and on diseases and their carriers in the Japanese mandated islands. The Stanford research associate is also preparing a brief manual on the distribution of tropical diseases and their carriers. A more comprehensive scientific work, to be

prepared later, will be of value to post-war reconstruction in areas of increasing strategic and commercial importance to the United States.

Allergy: Fifth Annual Forum.—This international postgraduate society will meet in the Hotel Statler in Cleveland, Ohio, the week end of January 9th and 10th, 1943. This Forum will offer a most intensive presentation both the new and the old in Allergy. The meeting will be characterized by its use of all the various types of instruction. Formal lectures, special talks, dry clinics, study groups, moving pictures, Kodachromes, panel discussions, ending with an "Information on Allergy, Please," will all be used to teach the physicians of the United States and Canada. Not only will specialists in this new field of Internal Medicine gather but also those whose interests are in allied fields of medicine will be welcome, for in war time every physician is called upon to advise and treat allergic patients. This is especially true of those in Internal Medicine, Diseases of Children, Diseases of the Skin, Diseases of the Eye, Diseases of the Nose and Throat, as well as those engaged in basic research in Immunology. A course in Immunology as it applies to Allergy will be given the week before by Dr. Eckers to a limited number of physicians and associates. Any physician interested in either or both of the foregoing is invited to write Dr. Jonathan Forman, 956 Bryden Road, Columbus, Ohio, for copies of the printed program and registration blanks.

Among the 58 Allergists participating in the program are many of the leaders in this field. Arthur Coca, M. D., of New York, will receive the Forum's Gold Medal for his outstanding contributions to the subject and will give the Forum's annual lecture on Allergy on Sunday afternoon.

Kenny Method Course Now in 6 Centers.—The fact that 1942 has been a light year for infantile paralysis has allowed the country to change over with a minimum of difficulty from the older method of treatment of the disease, particularly in the early stages, to the Kenny method. Up to the end of the first week of October there had been but 2,834 cases reported in all of the United States. This is in comparison with 6,850 for 1941 and 6,918 for 1940 during the same period. It would have been totally impossible to supply nurses and physical therapy technicians trained in the Kenny method for an additional 4,000 or more cases. As it is, in many parts of the country only insufficiently trained persons or those with no training in this method had to do the best they could.

Training facilities have been established by the National Foundation as rapidly as possible. Today doctors, nurses and physical therapists can go to any one of six places and receive good instruction. It is no longer necessary for everyone to go to the University of Minnesota. While Miss Kenny and her Australian assistants work only at that institution, each of the other places has trained personnel, associated with excellent educational institutions, in charge of the courses.

Aided by the Foundation, teaching programs are conducted at the following places, and information as to costs, dates of courses and admission policies can be secured directly from these schools and universities:

School of Health (Women)
Stanford University, California
Catherine Worthingham, Director

Children's Hospital Society
University of Southern California, Los Angeles
Lily Graham, Technical Director, School of Physical Therapy

University of Minnesota, Minneapolis
Director, Center for Continuation Study

Northwestern University Medical School, Chicago
Dr. John S. Coulter, Chairman, Department of Physical Therapy

D. T. Watson School of Physiotherapy, Leetsdale, Pennsylvania
Dr. Jessie Wright, Director

Physical Therapy Postgraduate School
Georgia Warm Springs Foundation
Dr. Robert L. Bennett, Director.

Virus of Infantile Paralysis: How It Enters the Body.—That the dreaded infantile paralysis virus may enter the body through the nerves of the mouth has been demonstrated by medical research at the Stanford University School of Medicine.

This is the first conclusive evidence of poliomyelitis infection by mouth in the early, preparalytic stage. Other suspected portals have been the nose and the intestinal tract.

"It would appear that the mouth and pharynx are readily vulnerable to penetration by the virus," Dr. Harold K. Faber, Stanford professor of pediatrics, and his assistant, Rosalie J. Silverberg, write in the current issue of "Science."

This does not exclude other possible portals of entry he emphasizes, but points out that "it is pertinent to note that the very frequent occurrence of headaches, vomiting, neck pains, and other symptoms in the preparalytic stage of the human disease strongly suggest early involvement of the brain stem which is better accounted for by entry through the mouth and pharynx than from the more distant intestines."

In Dr. Faber's research, the nerves of smell were excluded as a possible pathway by spraying the nasal passages with zinc sulphate. The animal had previously been fed virus in capsules and given an enema containing virus, both without producing the disease. However, when the mouth was sprayed with virus, unmistakable signs of the disease appeared within five days, although actual paralysis had not yet occurred. Microscopic evidences of infection were traced from the mouth along the course of the nerves of sensation and taste into the nerve ganglia, or relay stations, which lie outside the brain. The infection was also found just beginning to extend beyond these into the medulla oblongata, the lowest part of the brain which connects the brain with the spinal cord.

The discovery is considered important because the mouth is the first surface to be exposed to food and drink contaminated with virus, and, especially in the case of children, to fingers similarly contaminated and put in the mouth.

"In times of epidemic, special precautions suggested by these facts would be in order and might be of considerable preventive value," says the Stanford pediatrician.

Faulty Posture May Cause Maladies.—Certain symptoms of heart, bronchial and lung trouble may disappear if posture is corrected, according to Dr. William J. Kerr, Professor of Medicine at the University of California Medical School.

Observation of more than 300 cases at the Medical Center during a five-year period, declared Dr. Kerr, has led to the conclusion that many patients showing girth-obesity or having a relaxed abdominal wall may be relieved of anginal pains or pulmonary symptoms by means of a properly-fitted elastic abdominal belt. Acting as a means of artificial respiration, he explained, this aids in restoring the function of the diaphragm.—*U. C. Clip Sheet.*

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Are Doctors Being Hoarded?

There is a growing—and justified—concern over the draining of medical men out of civilian life into the armed services. The latest and most outspoken evidence of this concern was the preliminary report released by a senate labor subcommittee.

That report charged that "haphazard recruiting of doctors has led to a tremendous, unnecessary overmilitarization of the doctor supply at the expense of the civilian population" and warned that unless this "hoarding and freezing and unused doctors in the armed forces" is halted the nation faces serious consequences in civilian health.

It is a problem which warrants the most careful study. No one, of course, would argue that the armed services should not have all the doctors needed to maintain the health of the men at the highest level. But there is good reason to question seriously if as many doctors are needed as the army and navy believe.

The senate subcommittee report said the army and navy hope to maintain a ratio of approximately one doctor for every 100 men. For noncombat service that seems all out of proportion. Men in the armed services are the cream of the crop from a physical standpoint and should on the average require far less medical attention than the civilian population, yet the ratio of doctors in the civilian population prior to the war was about one to every 1,100 individuals—including not just young, healthy males, but children, old folks, women in pregnancy, the chronically ill and crippled.

The committee report said we had in the nation about 120,000 "medical effectives" and that one-third of them are already in the armed services, with another third scheduled to be called under the present army-navy program.

That is a dangerous situation, and for all we recognize the great importance of maintaining health in the armed services, we must (and the army and navy must) recognize the almost equal importance of maintaining health on the civilian front. Illness and breakdowns in health on the home front could wreck our march to victory by crippling war production just as surely as it could wreck it by crippling our military forces.

It has been reported that doctors in many of our army camps handle an average of three and a half patients a day. Anyone who has talked to doctors in the services knows that many of them feel their time is being wasted. One told this writer that all he did at a camp was "paint throats and hand out aspirin."

It's time for a careful restudy of our armed forces' medical needs. There should be one basis of medical staffing for men in noncombat areas and another basis for staffing in actual combat zones.

Certainly there is no need to build up a huge medical staff merely in anticipation of combat. A doctor doesn't need lengthy training to prepare himself for service with the army or navy. A month's time getting used to wearing a uniform and learning military routine should be ample. Why not call doctors into the service, give them such preliminary training and then release them to go back into private practice until there is actual need for their services?—Salt Lake City *Telegram,* November 9.

* * *

Public Will Always Get What It Pays For

During the past few weeks there has been much publicity in regard to a low cost medical care insurance plan for the lower income farm families. Those affected by such a plan are entitled to know its details. Publishing of the details, however, does not mean endorsement of that program. Individuals or groups get in this world just what they are willing to pay for. That applies to services of individuals in the medical, legal or engineering worlds as well as to the materials that are used in the economic life. If the individual or group places a minor amount as a limit to be paid per yard of material, that material will not be pure silk or linen.

The medical profession has forgotten to collect as much as it has collected in caring for low income or destitute people. None have ever been denied the services of a reputable physician or surgeon in an hour of real need.

In the medical world, just as in any other economic work of life, training, ability, constant study, experience and devotion to work gauge the success upon which the value of services are based. When there shall cease to be a reward for effort, that effort shall cease and humanity will pay the penalty.

Utopia is not for this world and the more quickly the average individual learns this the more quickly will be benefit, mentally, physically and financially.—Madera *Tribune and Mercury,* November 12.

Solution for Doctors' Plight

More and more members of the medical profession are going into military service every day.

Young doctors just out of medical school, doctors who have barely established themselves in the community, and long established men who would soon begin to shift the burden of their practice to new partners, are donning uniforms.

For the medical people remaining at home, the task has become gigantic. But, one and all, they are grimly determined that essential medical care will be provided for civilians.

There are many ways in which the layman can help in this medical crisis. He can guard his own physical well-being by keeping regular hours and eating and sleeping properly. He can be tolerant if he is kept waiting for an appointment. And he should follow fully the advice of his doctor in order to return himself to full usefulness as soon as possible.

The small number of doctors left in Alameda have pledged themselves to take good care of our civilian needs but they can only fulfill their promise if they have the coöperation of every Alameda resident.

It stands to reason that there are not enough doctors still in Alameda to personally answer every sick call and interview every person who visits their offices.

The number of doctors in this city is rapidly diminishing. But the population is increasing by leaps and bounds and, therefore, the number of sick calls is mounting constantly.

Local doctors are carrying a tremendous burden and it will only be reduced if every citizen does his share.

Alamedans should guard their health now more closely than ever before. They should not call a doctor to their home unless it is absolutely essential. They should remember that in cases of minor illness, doctors and their nurses can properly pursue their duties by prescribing for the patient over the telephone.

If everyone keeps these things in mind, doctors will be able to carry on with the least possible trouble.

Alamedans must pull together. Don't summon your doctor to your house unless he is urgently needed. He can prescribe for a number of ills over the telephone—and will do so happily.—Alameda *Times-Star,* November 10.

* * *

Do Your Part to Help Save Doctors' Time

About one out of every three doctors practicing medicine in the United States is now in the armed services. It may not be long when this will be increased to one of every two. Those who are left tend to be the older and less robust, consequently those least able to carry heavy additional burdens of practice. Patient coöperation is a necessity for effective medical care during the remainder of the war.

Every individual who is old enough should learn first aid as taught in Red Cross classes and by Boy and Girl Scouts. Every person should learn how to eat intelligently, so that health may be maintained. Wise use of shelter and clothing should help to cut down colds, pneumonia and other results of exposure and chilling.

Look Ahead

All persons should procure for themselves or for their children the immunizations against communicable diseases which are devised by medical and public health authorities; these include small pox vaccination for everybody not successfully vaccinated within five years, diphtheria prevention for all children at the age of eight months, typhoid vaccination for all in certain localities, and under special circumstances as advised by the doctor, protective inoculations against whooping cough, scarlet fever, lockjaw and yellow fever.

Every one should learn the signs which indicate serious illness; unconsciousness, drowsiness or stupor; excessive excitement, irrational conduct, high or persistent fever, severe pain, persistent mild pain; "shock" or collapse; appearance of blood in bodily discharges; abnormal growth or swellings; and "upset" which does not show signs of improvement in 24 hours. These signs do not always indicate serious disease, but they do constitute reason for calling a doctor to be sure what they mean. In any case of uncertainty call the doctor; give the patient the benefit of the doubt.

Call in Morning

When calling the doctor call him early in the morning during his office hours or at noon so he can plan his calls with the least amount of travel and time. Go to him whenever possible instead of asking him to come to you. If he must come to you give him as good an idea as possible what sort of illness he may expect

to find. In anticipation of his departure for military service ask him what doctors he recommends; if he has gone call his home or office and ask if he has left such recommendations.

Hospitals are having many hard war problems, too. You can help by using hospitals only as your doctor advises.—San Francisco *News*, November 10.

* * *

Behind the News: With Arthur Caylor

Comments Concerning Kaiser Hospitals

The battle Henry J. Kaiser has been enjoying with the doctors of Portland may have repercussions that will affect many San Franciscans—already hit by a constantly worsening doctor-nurse-hospital shortage. For the Kaiser plan to provide "socialized medicine" to workers and their families already has gone up to the American Medical Association. The reaction of that body, my men report, may have much to do with the methods whereby any attempt is made to provide wartime medical service to civilians here.

It wasn't alone Kaiser's intention to provide medical service to their families as well as to the men which made the Portland doctors see red. Part of their anger was due to the fact that—at a time when they couldn't get a new gadget for existing hospitals—Kaiser flashed a shiny new hospital on them that was full of chromium, steel, copper and other forbidden metals. Where the doctors couldn't get instruments, it was evident that Kaiser could. His hospital even included a maternity ward, although at the time it was planned the shipyards weren't using any pregnant welders.

The reaction of the doctors was a bit swifter and hotter than that of an ordinary Joe Blow who walks into the office of some peanut official and finds he's making a career of the war. The office is full of thick carpets, steel desks, metal filing cabinets, extra-fancy lights, and other things the common people either can't have or soon won't be able to get. It makes the gorge rise, doesn't it?

Dope is, however, that the A.M.A. won't let anger get the better of its judgment. Some of its top men insist unusual steps must be taken to meet the emergency. If that involves doing some things the Kaiser way the doctors will do those things the Kaiser way.—San Francisco *News*, November 26.

* * *

'War Heart' Greatest Menace, Doctors Say

In a dim amphitheater at the University of California Hospital where the murals on the walls depict the progress of surgery since the days when a "surgeon was a dentist," 200 doctors from six states met on November 6, to talk over the problems that face the medical profession, mobilized for wartime duty.

And the problems, they agreed, were these:

A "war heart" is the greatest menace that faces a civilian population.

The scarceness of doctors is reaching alarming proportions.

The man on the street must calm down and the skittish race to live 24 hours in every day must be stopped.

Don't call your doctor unless you need him on an essential duty call.

The "red tape" of the Army, which called into service all medical men of what is termed a "fighting age," is cumbersome and binds doctors, vitally needed for civilians, to waiting three months before they can be used on hospitalization cases.

Nervousness Cited

The increase of public nervousness, which leads to "war hearts" is a potential Axis asset, and if not curbed will develop into cardiac disorders the medical profession cannot meet because it doesn't know how.

Those were the startling statements given at the 13th annual postgraduate symposium on heart disease, held in the gray-white University of California Hospital, where men from the sparse areas of Arizona, Nevada, Washington and California mingled with the surgeons and specialists on health from the cities. . . .

When the assembly, which is affiliated with the American Heart and California Heart Associations, opened yesterday, Dr. T. Duckett Jones, nationally known expert on cardiac disorders, professor at the Harvard Medical School, warned sternly that "while the public is more tolerant today than a few months ago, it must realize that 100 per cent of intellectual consideration is worth 100 per cent of medical care."

"Schools are the greatest source of localities that cause the spread of streptococcus infections which lead to cardiac disorders," he said, nodding his head for emphasis. "If parents would only realize that it is better to keep a child who is coughing out of school and if the schools only realized that thinking is more important than attendance—there's the answer to health."

An expert on rheumatic fever, which constitutes one-third of all cardiac diseases and is particularly prevalent in San Francisco among children, Dr. Jones told the assembled surgeons in the theater of the hospital that "this is our greatest killer and the only answer rests in adequate housing conditions, which each patient may be alone for the rest and quiet that is necessary for cure.

Must Take Rest

"Public nervousness is increasing due to uncertain conditions," he said, "but must be stopped by the individual taking a few hours of rest or else we face a population that is jitterish and vulnerable to heart rheumatism that results from that condition."

He said he had noted a particularly noticeable increase since the war broke out and urged that the "problems of the heart be met by community action." . . .

The meetings began yesterday and will continue today and tomorrow, all devoted to technical clinical discussions of heart ailments, and held under the direction of Dr. J. K. Lewis, chairman; Dr. Dorothy Atkinson, Dr. Charles A. Noble, Marjorie Edwards and others of the Heart Committee.—San Francisco *News*, November 6.

* * *

A.M.A. Fights Trust Charge as Improper

Medicine a Profession, Not Trade, High Court Told

Washington, Dec. 11.—Counsel for the American Medical Association told the Supreme Court today that its conviction under an anti-trust indictment was improper because doctors practice a profession, not a trade.

The Government argued, however, that the Association had carried on activities aimed at group health association "principally for economic reasons" and that the Sherman law therefore applied.

Denies Contention

Seth W. Richardson, Washington attorney for the Association, asserted that the 1890 Sherman Act prohibited conspiracies in "restraint of trade" and that this was the first case in which "anyone suggested that the field of learned professions should be considered as a trade."

The attorney contended that restraint must be "commercial in its operation" to be prosecuted under the anti-trust law and that the Supreme Court had so held.

Validity of the conviction of the Association and an affiliate, the Medical Society of the District of Columbia, was defended by John Henry Lewin, special assistant to the Attorney General. He asserted that the organizations had attempted to destroy Group Health Association, Inc., described as a nonprofit coöperative association of Government employees in the District of Columbia.

Fined $2,500

They were convicted in the United States District Court here and the national association was fined $2,500 and the local society $1,500.

Arguments will be resumed Monday by Thurman Arnold, assistant Attorney General in charge of anti-trust law enforcement, and William E. Leahy, another Washington attorney for the organizations.

Lewis said the indictment alleged that "A.M.A. has long been opposed to the group practice of medicine on a risk sharing, prepayment basis—the basis upon which group health provided medical care—and that this opposition has been principally for economic reasons and because A.M.A. fears the competition which this kind of practice offers to its doctor members, who practice on the customary fee for service basis."—San Francisco *Examiner*, December 12.

* * *

Idaho's Dilemma

The State of Idaho is between the horns of one of those dilemmas resulting when too many people make binding promises, but without unity of objective. The same voters elected lawmakers from both parties pledged to cut State expenses approved also a pension measure so liberal that its adoption could mean only an increase in State disbursements, and that would mean higher taxes.

Among the provisions of the pension bill are $40 monthly cash allotments for all aged residents, eyeglasses and artificial limbs and teeth for those needing them, $8 monthly medical care for every citizen 65 years of age or older, and $100 burial costs for every pensioned person.

We do not know how things will work out in Idaho. But there is the precedent provided by Colorado. It will be recalled that the voters in that state approved a grandly liberal pension bill that simply had to be repudi-

ated for the very practical reason that there was not the money available for making good on the plan.—Palo Alto *Times*, November 20.

* * *

San Diego Hearing on Liberalizing Hospital Rules

San Diego—Liberalization of present county hospital rules to permit admission of any patient needing emergency hospitalization and for care by any licensed surgeon or physician, will be discussed at a hearing before the county supervisors November 9.

The county welfare department hospital admissions committee submitted a recommendation to the supervisors Monday urging changes in the present rules to meet wartime conditions.

The committee recommended that "in this emergency any licensed physician and surgeon may enter a pay patient into the county hospital as in any accredited private hospital subject to county hospital rules."

Supervisor Dean Howell said that before he voted to accept the committee's recommendations, he would like to hear expressions of private physicians and representatives of medical institutions as to the practicability of modifying the hospital rules. Dr. B. A. Adams, county hospital superintendent, also will be asked to attend the hearing.

Howell's views were concurred by the board. . . .—Oceanside *Blade-Tribune*, October 20.

* * *

Pension Law Stumps Idaho

Liberal Measure, Voted by People, Threatens Headaches for Taxpayers

Boise, Idaho, November 17—(AP.)—Artificial limbs and teeth, eyeglasses and $40 cash per month are promised Idaho's aged residents in the State's new pension act.

The law, which also provides for $8 in medical care monthly for each citizen 65 or older and $100 per person burial costs, threatens plenty of headaches for the State's legislators and taxpayers.

Approved by popular vote in the recent election, opponents call it one of the most liberal pension measures in the nation and assert it might cost as much as $5,250,000 a year.

Members of the new General Assembly meeting in January already are wondering how they'll raise money to pay it, in the face of preëlection vows by both parties to cut expenses.

Legislators have at least three courses open: refuse to appropriate funds, amend or repeal the act, or boost tax revenues.—Los Angeles *Times*, November 18.

* * *

Dorothy Thompson's Views on Medical Set-Up in the Future

Excerpt follows:

I submit we won't. I submit that at no distant date after this war is over some future Donald Nelson will arise and say to the National Association of Manufacturers, who by that time will have gotten over the shock:

"Gentlemen, I am pleased to report that we have within the last 12 months abolished one-third of all the slums, urban and rural, in the United States. We are behind our program, however, and are not yet using our resources to the fullest.

"Our program for the next year includes the perfection of a hospital network that will not leave a community without the most modern facilities for medical care. The decentralization of industries, with a view to bringing the factory to the farm, instead of the farm to the factory, is making great progress.

"I thank you, and the American farmer and worker, for the splendid vision and coöperation that began the day after Pearl Harbor and has proceeded uninterruptedly ever since."—San Francisco *Chronicle*, December 11.

* * *

'Child Welfare Problem Grave But State Has Forged Ahead'

Federal Bureau Chief Here, Says There's Help in Sight from Congress

While conceding that California has a serious child welfare problem, Katherine Lenroot, chief of the U. S. Children's Bureau, in San Francisco, on November 9th, said that "this state has gone far in laying the foundation of care for children in war time."

Miss Lenroot, in San Francisco for a series of meetings with local child welfare authorities, declared that welfare problems are greatest in areas where there have been large increases of industrial population and where doctors, nurses and social workers have been drawn off for war service elsewhere.

She said that to ease the situation, a bill is pending in Congress which will provide additional funds for child care services through the Social Security Act.

"These funds will strengthen the service for mothers and children in defense areas, both military and industrial," she explained. "Maternity and medical care of infants and children of service men will be expanded.

"They will also meet the special problems of neglect and delinquency and strengthen the community programs for possible evacuation of children in case of enemy attack. A large part of the added money will extend day care service for children of mothers working in war industries."

Miss Lenroot was the principal speaker at a luncheon meeting at the Bellevue Hotel, sponsored by the Social Planning Committee of the Community Chest and representatives of social agencies in Oakland and Berkeley.—San Francisco *News*, November 9.

* * *

'U. S. Hospital Crowding to Grow Worse'

'Bed Shortage Is Threat to Health of People at War'

Chicago, November 12—(UP.)—The nation faces a serious hospital shortage, which in some cases already has forced the establishment of wards in corridors and the turning away of patients, E. K. Gubin, writer for "Hygeia" magazine, said today.

Mr. Gubin said indications are that conditions will be worse before remedial steps can be taken.

"To carry on the war effort successfully our workers must be healthy and stay healthy," Mr. Gubin wrote, but a shortage of facilities prevents adequate care for the sick.

"Eighty per cent of bed capacity is considered the maximum at which a hospital can operate efficiently," he said, "but according to Dr. Donald K. Freedman in a recent article in The Journal of the American Medical Association, many hospitals now continually have occupancy rates of 100 per cent or more."

Mr. Gubin said within the last 10 years more than 500 million dollars has been spent on hospital projects by the Federal Works Agency and others, but despite an increase of more than 100,000 beds, facilities remain inadequate.—San Francisco *News*, November 12.

* * *

Extension of Sterilization Law Favored

Heads of 16 State Institutions Urge Inclusion of Sexual Psycopaths; Parole Peril Cited

Sacramento, Nov. 12—An extension of California's sterilization program to include persons adjudged by courts to be psychopathic delinquents and sexual psycopaths was recommended today at a conference of heads of sixteen State institutions.

Under the present law governing State insane asylums and feeble-minded homes, the State can sterilize only persons adjudged by the courts to be feeble-minded or to be afflicted with certain types of insanity.

Seek Job Waivers

Looking forward to the legislative session next January, institutions heads also recommended that residence requirements be waived on all State civil service jobs involving institutions, and suggested that legislation to provide a minimum commitment for alcoholic patients at State hospitals be provided by law.

The extension of the sterilization program would require specific legislation, said Dr. F. O. Butler, acting director of institutions, because the attorney general's office has held that the present sterilization program can not legally include psychopathic delinquents or sexual psycopaths.

"There may be some public criticism of our action (in recommending extension of sterilization)," Doctor Butler said, "but we must face it. Psycopathic and mentally defective delinquents and sexual psycopaths should not be turned loose on society in their present state."

Peril of Parole

Dr. R. B. Toller, superintendent of the Mendocino State Hospital, urged legislation permitting sterilization of sexual psycopaths and said it is virtually impossible to keep such patients in State institutions for the rest of their lives.

"Many will be released on parole," he said, "and there is no way of knowing whether they will repeat their acts."

Many persons benefited by the expanded sterilization program can never be cured of their defects by hospital treatment, said Dr. G. Max Webster, superintendent of Patton State Hospital.

"They are born that way," he said, "and will never be any different."—San Francisco *Examiner*, November 13.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Bill For Medical Services as a Preferred Claim Against the Estate of a Decedent

Section 950 of the California Probate Code sets forth the order in which the debts of a decedent shall be paid out of the assets of his estate. Of interest to the medical profession is the fact that the "expenses of the last illness," which include a bill for medical services, is third in the order of payment, and by this section is given priority in payment over all debts of the decedent with the exception of expenses of administration and funeral expenses. The result of this section is that in the case of an insolvent estate, if there are assets owned by the decedent at the time of his death sufficient to take care of the funeral expenses, normally the physician attending the decedent at his last illness will be paid for his services rendered.

Recent inquiries received by the writer call attention to the fact that there is a conflict between the above mentioned section of the California Probate Code and the laws of the United States, in that the state statute gives the expenses of the last illness of the decedent preference over practically all debts, including those having preference by the laws of the United States.

The question as to whether a bill for medical services rendered in connection with the last illness of the decedent should be paid prior to debts due the United States will arise whenever the assets in the estate of a decedent are not sufficient to pay both claims. In such event, it is necessary to resolve the conflict between the above mentioned state statute and Title 31, United States Code Annotated, Sec. 191, which provides in part as follows:

"Whenever any person indebted to the United States is insolvent or whenever the estate of any deceased debtor in the hands of the executor or administrator is insufficient to pay all the debts due from the deceased, the debts due to the United States shall be first satisfied; . . ."

For example, a claim of the United States government against a decedent for unpaid taxes would constitute a debt due to the United States from the decedent and by the terms of this section of the United States Code must be satisfied before any of the other debts of the decedent are paid. In the event there were not sufficient funds available in the hands of the executor or administrator of the decedent's estate to pay both expenses of the last illness and any taxes owing by the decedent to the United States, the physician's bill would remain unpaid. Such a result would be in direct conflict with the state statute.

The Superior Court of the State of California, in Los Angeles County, recently was presented with such a problem. At the time of the death of the decedent, there were owing by said decedent social security and unemployment taxes to the United States and there were not sufficient assets in the estate to pay the full amount of these claims. In addition, there was a bill for medical services rendered in connection with the last illness of the deceased due to the physician who had attended during the last illness. It was necessary for the court to decide whether to give effect to the state statute which would require the payment of the physician's bill or to follow the terms of the federal statute which gave the claim for social security and unemployment taxes priority in payment over all other debts of decedent. The Court ruled that Title 31, Sec. 191, of the United States Code governed and that the claim for taxes must be paid. The result of such determination was that the physician received no compensation for his services.

Apparently, there are no decisions by any higher court in the State of California directly interpreting the conflict between the provisions of our statute and the above quoted section of the United States Code, but, in the opinion of the writer, the decision of the Superior Court, in Los Angeles County, was correct. It has been held, in other jurisdictions, that the priority given to the United States by this section cannot be impaired and that this section must prevail over any state law providing to the contrary.

In *Estate of Barriero,* 125 Cal. App. 153, the District Court of the State of California inferred that they would hold any claim for income taxes due to the United States to have priority over all other debts of the decedent. This would indicate unfortunately that the decision of the Superior Court of Los Angeles County was correct in holding that a claim of the United States for social security and unemployment taxes accruing during the lifetime of the decedent should be afforded priority of payment over the claim of a physician for medical services rendered the decedent in connection with his last illness. The attitude of the courts of our state with respect to payment of taxes is illustrated by the following quotation from *Estate of Morris,* 37 Cal. (2d) 155, involving a claim due for state sales taxes. In discussing and approving decisions of the Federal Courts giving claims for taxes priority in payment over other claims against the estate of a decedent, the State Supreme Court said:

"These cases proceed upon the theory that the maintenance of the government and the public welfare are so dependent upon the collection of taxes that payment should have precedence over all other claims and it is thought that taxes levied for the support of government are founded upon a higher obligation than other demands."

Recognizing the serious consequences to the medical profession, it is nevertheless only logical to conclude that the collection of taxes lawfully imposed by the federal government cannot be made dependent upon state law in such manner that a state statute could give priority to the payment of a physician's bill in preference to the payment of taxes owing by the decedent at the time of his death.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning California Institutes on Wartime Industrial Health

(COPY)

ROBERT T. LEGGE, M. D.
Berkeley, California

Nov. 27, 1942.

Dear Doctor Kress:

As Chairman of the recently held Institutes on Wartime Industrial Health, I desire to thank you for the personal interest you have taken in these Institutes, the advice rendered, the great publicity, and the publication of the papers in CALIFORNIA AND WESTERN MEDICINE. It was a timely and a constructive contribution of the California Medical Association. I also read with much interest the editorials in the October number of the Proposed Section on Preventive and Industrial Medicine and Public Health. I am sure it will please the members of our profession who are in public life engaged in these fields.

With kindest regards,

Yours sincerely,
(Signed) ROBERT T. LEGGE, M. D.

* * *

San Francisco, December 1, 1942.

To the Editor:—With respect to the California Industrial Hygiene Institutes, I think we have hit upon a pattern here which can be used to great advantage for the physicians in this State. As soon as opportunity presents, I hope we can get together on similar programs in the near future.

I am keenly interested in the suggestion that we make a greater welcome for the public health physicians of the State in the California Medical Association. Please count on me for any assistance you may wish to further this splendid idea.

Sincerly yours,
(Signed) W. P. SHEPARD, M. D.

Concerning Social Hygiene Day: February 3, 1943

To the Editor:—Social Hygiene Day will take its battle stations throughout the country as in former years, despite the gasoline and rubber restrictions which are in force this year. Doctor Walter Clarke, Executive Director of the American Social Hygiene Association, in announcing the annual observance scheduled for Wednesday, February 3, 1943, said that this battle on the home front against venereal disease is nation-wide and does not depend upon transportation to rally its fighting forces.

Syphilis and gonorrhea are enemies which threaten us at home. They disable our men at the front, but their roots are on the home front.

During the first World War, there were 157,146 more new cases of syphilis and gonorrhea among United States soldiers, sailors and marines, Doctor Clarke explained, than there were wounds in battles. Total absences from duty due to this infection kept the equivalent of 20,600 men out of the fighting for a whole year, men trained for their country's service, men upon whom their country counted for its defense.

In terms of today's hard held fronts such a loss would mean the equivalent of the personnel required to man five huge aircraft carriers and nine destroyers. No axis enemy could be more destructive than this enemy whom we must defeat on health battle fronts within our own country. We do not need to suffer this loss and do not need gas and tires to meet that enemy and to destroy him. We have the scientific weapons to prevent the spread of the venereal diseases. In war time the principal function of social hygiene organizations everywhere is to persuade every community to use these weapons effectively. Intelligent coöperation among the health and welfare agencies in every city and town will help stamp out venereal disease and thus help our armed forces to bring us victory on the battle fronts.

(Signed) AMERICAN SOCIAL HYGIENE ASSOCIATION.

Concerning B.M.I. Hospital at Las Vegas: F. E. Clough, M. D., Formerly of San Bernardino, in Charge

To the Editor:—In the B.M.I. Hospital, we aim:

To give to its patients the best medical care;

To do everything which will return the patient to health with the utmost expedition;

To do these things in the spirit of kindly, wholehearted personal service.

With these words emblazoned on a plaque, the new B.M.I. Hospital was opened for service Sunday, after a dedication ceremony in which patriotism, medical ethics, and the concern of modern industry for the welfare of its employees featured a simple, impressive ceremony.

The new hospital of "Basic Magnesium," at Las Vegas, though erected primarily to take care of accidents to employees and provide medical service for them, will also be open to families of project employees when need arises and, of course, only when space is available. Charges for these services will be commensurate with services performed, and will conform to rates prevailing in this locality. Physicians on the staff, making calls on patients, will also charge in accordance with rates governing in this area.

Relatively New in Industry

The big and important thing about the new hospital is that it represents something relatively new in American industry. Embodied in its physical structure and the apparatus and equipment which it houses, the hospital is a monument to the insistance of modern industry that the health and safety of employees is of vital importance.

Equipment the Latest

No industrial hospital in the world is better equipped to give high type hospital and medical service. In all departments the very latest equipment evolved by medical science has been installed. No pains and no money has been spared to guarantee that men and women on this project will have the best.

Very truly,

F. E. CLOUGH, M. D.

N. F. Sprague, D.O., Given U. C. Regent Post

Sacramento, Nov. 10—Gov. Culbert L. Olson today appointed Dr. Norman Frederick Sprague, Los Angeles osteopathic physician, to the board of regents of the University of California to fill the unexpired term of the late Garrett McInerny, San Francisco.

Dr. Sprague is managing director of the Wilshire hospital of Los Angeles, a member of the State board of health, and was appointed by Olson as a surgeon of Statewide reputation. His appointment, the first "lame duck" appointment made by Olson since his defeat for reëlection, runs until March 1, 1952.—San Bernardino *Sun*, November 11.

Births Going Up

Birth statistics of the United States for 1941 reveal a birth rate of 18.8 against 17.9 the preceding year: a total of more than 2,500,000 babies born (greatest number since 1921's 2,600,000); and that births exceeded deaths by 1,090,000.—San Francisco *News*, December 7.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 12, December, 1917

EXCERPTS FROM EDITORIAL NOTES

Medical Patriotism and the State Society.—It has been iterated and shall be reiterated that patriotism consists in actions as well as words and, of the two, actions are the more important. From the beginning, American men of medicine have been noteworthy for their maintenance in vigor and purity of the institutions and ideals of their country. Nor have they fallen short in the present emergency. The response in California to the summons of the Army and Navy is enthusiastic and liberal. Our quota will be provided. There are, however, certain less public and obvious fashions of expressing and rendering patriotic service, and these must not be lost to attention. . . .

Hence comes the necessity now for the physician in California to assume his public rôle as he has not done heretofore. Hence the necessity for him to organize as he has not done before. Organization and efficient assumption of these public obligations by the medical profession are thus a definite and clear public duty. They are a necessary form of patriotic service. The doctor who conscientiously or of necessity is not in uniform, cannot escape this obligation. If he is neither in service nor in the organized ranks of his profession, then he is a slacker from the obligations of a public nature which rest on our profession today. The war is a trumpet call for every reputable physician to enroll in his local county medical society, and help direct and extend the useful functions of the State Society. . . .

More Medical Officers.—At the last meeting of the Council of National Defense, Medical Section, a complete list of the physicians in California who have entered the Medical Officers' Reserve Corps was presented. Their number totals to date 665 men. The entire number required from the State is 800. It is therefore apparent that there are approximately 135 men yet to volunteer for military service. . . .

How many physicians, you included, can sign their names legibly? How many can write a legible prescription? And if they can, how many actually do these things? It would surprise many a doctor to know the difficulty and legal penalties which not infrequently follow an unintelligible signature on the records of the secretary of the State Society and of the State Board of Medical Examiners. In the present day of typewriters, every communication for publication, and most for correspondence, should be typed, with good margin, double spaces and, above all, with a legible signature. Observe your handwriting objectively and see if it really is legible.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Diseases of War: Their Prevention, Control and Treatment (The Handling of Infectious Diseases in the Field)", by Major Lloyd L. Smith, Medical Corps, United States Army.—The diseases responsible for the greatest losses in war may be practically divided into two main groups: (a) those of

(Continued in Front Advertising Section, Page 10)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twnety-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners, held in the Business and Professions Building, Sacramento, October 19 to 22, the following officers were elected for the ensuing year:

President—Percival Dolman, M. D., San Francisco.

Vice-President—George Thomason, M. D., Los Angeles.

Secretary-Treasurer—Charles B. Pinkham, M. D., San Francisco.

Dates for meetings, for the year 1943, will be as follows:

March 8 to 11, inc., Elks Club, Los Angeles.

July 12 to 15, inc., San Francisco.

Aug. 9 to 12, inc., Elks Club, Los Angeles.

Oct. 18 to 21, inc., Sacramento.

The following changes were made in the status of California licentiates, after hearing before the Board:

John Joseph L. Doyle, M. D., Certificate revoked Oct. 22, 1942.

Newton T. Enloe, M. D., on Oct. 20, 1942, placed on probation for a period of one year.

Thomas Flint, Jr., M. D., on Oct. 22, 1942, placed on probation for a period of five years.

Gordon Havstad, M. D., on Oct. 20, 1942, reprimanded.

George Carl H. McPheeters, M. D., on Oct. 22, 1942, revoked.

Chester D. Sewall, Revoked Oct. 20, 1942.

Philip John Murphy, M. D., was on Oct. 22, 1942, found guilty on Counts 1 and 2 of the Complaint and penalty was deferred to the Los Angeles meeting.

The certificate of Samuel D. Burgeson, M. D., revoked Oct. 19, 1937, was restored Oct. 22, 1942.

The following cases were continued for hearing to the Los Angeles meeting:

William E. Glaeser, M. D., Herbert B. MacRae, M. D., Charles Pius, M. D., William Walter Reich, M. D., Darrington Weaver, M. D., Charles Roy Wright, M. D.

Seventy-two applicants of various classes wrote the examination, including several graduates of foreign medical schools.

News

"Dr. R. H. Bean, D. C., a chiropractor with offices in the Forum Building, was booked in the city jail on a charge of violating the business and professions code by prescribing medicine for a patient. . . ." (Sacramento *Bee*, October 30, 1942.)

"F. M. Koyle, 65, a shipyard worker, was fined $50 and placed on two years' probation, on a charge of practicing medicine without a license, in Oakland Police Court, yesterday. The charge was brought after an in-

(Continued in Front Advertising Section, Page 22)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

NEXT ANNUAL SESSION
California Medical Association, Hotel Biltmore, Los Angeles. May 2-3, 1943.
American Medical Association. Scientific Meetings Cancelled.

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